DOCUMENT RESUME

ED 210 829 EC 140 609

AUTHOR Walker, Kay P., Ed.; And Others
TITLE Project Sunrise Proceedings Document. The Annual Montana Symposium on Early Education and the Exceptional Child (2nd, Billings, Montana, April 1-3, 1981.)
INSTITUTION Eastern Montana Coll., Billings. Inst. for Rehabilitative Service.
SPONS AGENCY Bureau of Education for the Handicapped (DHEW/OE), Washington, D.C.
PUB DATE Apr 81
NOTE 217p.

EDRS PRICE MF01/PC09 Plus Postage.
DESCRIPTORS Autism; Burnout; Computer Assisted Instruction; *Cost Effectiveness; *Disabilities; Early Childhood Education; Home Instruction; Inservice Teacher Education; Interdisciplinary Approach; *Labeling (of Persons); *Program Development; *Rural Education; Seizures; Student Evaluation; Teaching Skills; Team Teaching

ABSTRACT

Four keynote speeches and 14 sectional presentations comprise the proceedings of the April 1981 Montana Symposium on Early Education and the Exceptional Child. The first speech, entitled "The Yellow Brick Road--Does it Lead to Oz or Abyss?" by B. Fredericks, stresses the importance of gathering solid research evidence to demonstrate that early childhood programs for the handicapped are not only educationally beneficial but also cost effective. A second speech by Fredericks, "The Country Children--Who Serves Them?" describes two methods of serving rural handicapped children, the rural aide model and a parent training model. N. Haring, in "How to Tell Who You're Teaching Without a Label," stresses the disadvantages of labeling handicapped children and proposes that intervention strategies be identified instead. M. Karnes offers "Components of an Exemplary Program for Young Handicapped Children" and stresses the value of each individual, the child, his/her family, and the staff. Sectional presentations have the following titles and authors: "Creative Use of a Resource Library for Meeting Teacher Competencies, Serving Native American Pre-Schoolers" (S. Bailey); "Interdisciplinary Inservice Training for Identification/Assessment of Preschool Handicapped Children: A Functional Planning Model" (D. Banman, E. Husband); "Independence M. S. Agency Addiction--Dollars and Sense of the Home Training Model" (S. Dow, R. Wheeler); "Focus on Teaming--Training Interdisciplinary Teams for Preschool Programs" (M. Flynn); "Burnout--Symptoms and Solutions for Teachers and Parents" (M. Hagen); "Modifying the Pre-School Environment to Meet the Needs of the Seizure Disordered Child" (A. Hilton, G. Gay); "How the WISP Was Won--A Model of Services for Handicapped Infants and Toddlers" (J. Jelinek, et al.); "Assessment and Evaluation Techniques with Infants and Young Children" (C. McKennan, W. Nickoloff); "Administrative Issues in Developing Programs for Pre-School Children" (N. Owings, L. Holmquist); "Project Family Link I--A Home-Based Intervention Program for Young Handicapped Children and Their Families" (M. Riley); "Teaching Self-Control to Young Handicapped Children" (S. Robertson); "Facilitator---An Alternative Service Model" (B. Stilwell); "Computer Assisted Instruction---New Help for Special Education Students" (R. Swenson, J. Kingman); and "Ideas and Programs for Autistic Children in the Public School" (J. Syndergaard). (DB)

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# PROCEEDINGS DOCUMENT

## SECOND ANNUAL MONTANA SYMPOSIUM ON EARLY EDUCATION AND THE EXCEPTIONAL CHILD

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EASTERN MONTANA COLLEGE
Billings, Montana 59101

PROCEEDINGS DOCUMENT

# THE SECOND ANNUAL MONTANA SYMPOSIUM

on

# EARLY EDUCATION AND THE EXCEPTIONAL CHILD

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PROJECT SUNRISE OUTREACH
INSTITUTE FOR HABILITATIVE SERVICES
EASTERN MONTANA COLLEGE
BILLINGS, MONTANA

NORTHERN HOTEL
BILLINGS, MONTANA
April 1-3, 1981

This document was supported by a grant from the Bureau of Education for the Handicapped, Office of Education, U. S. Department of Health, Education and Welfare. Grantees undertaking such projects under governmental sponsorship are encouraged to express freely their judgment in professional, technical matters. Points of view or opinions do not, therefore, necessarily represent official Office of Education position or policy.

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## PREFACE

Increased awareness of the critical need for earliest possible intervention with young handicapped children has presented service providers of geographically isolated areas with a unique set of challenges. In an effort to address the issues of service delivery in rural America, the Montana Symposium on Early Education and the Exceptional Child became a reality in February, 1980. Participants enthusiasically supported the concept of an annual symposium.

On April 1-3, 1981, the Second Annual Montana Symposium on Early Education and the Exceptional Child was held in Billings, Montana. The symposium was jointly planned and executed by Project Sunrise Outreach, School of Extended Studies & Community Service of Eastern Montana College and the Department of Special Education for the State of Montana.

The symposium was designed to further the advancement of knowledge and techniques in serving young handicapped children and their families residing in rural areas. A "call for papers" issued in the fall of 1980 resulted in a cadre of expertise and experience. Twenty presenters representing nine states ultimately participated with topical presentations.

Keynote addresses delivered by Dr. Merle Karnes, University of Illinois, Dr. Norris Haring, University of Washington, and Dr. Bud Fredericks, Teaching Research, Monmouth, Oregon provided a wealth of expertise to the more than 200 participants. In addition to the major addresses, the speakers conducted individual sectionals throughout the symposium.

The symposium proved to be a highly successful endeavor. Participants developed professional liaisons, enhanced their knowledge and understanding of issues and concerns facing handicapped rural America, and took advantage of the opportunity to share their concerns with nationally respected leaders in the field.

The development of this manuscript is the result of a concerted effort by

specialists in the field to share their expertise with others facing the challenge of service delivery in rural America.

I would like to offer my sincere appreciation to Dr. Merle Karnes, Dr. Norris Haring and Dr. Bud Fredericks for their efforts and contributions in the development of this document. Special thanks is given to my friend and colleague, Dr. Ronald P. Sexton, for his support and encouragement in this endeavor.

Kay P. Walker
July 6, 1981

THE YELLOW BRICK ROAD

DOES IT LEAD TO OZ OR ABYSS

THE COUNTRY CHILDREN

WHO SERVES THEM AND HOW

BUD FREDERICKS, ED. D., RESEARCH PROFESSOR

TEACHING RESEARCH, MONMOUTH, OREGON

# THE YELLOW BRICK ROAD

# DOES IT LEAD TO OZ OR ABYSS

Bud Fredericks, ED. D. Teaching Research

Research Professor Monmouth, Oregon

## Prologue

The original purpose of this keynote address was to share with you the progress of early childhood education for the handicapped. Recent events have caused me to alter the address somewhat but the ultimate message will still be the same. It is that the future of early childhood education of the handicapped rests squarely on the shoulders of you, the professionals who provide service or do research regarding early childhood education.

In 1958 the major impetus for handicapped early education came from the work of Sam Kirk. He demonstrated that handicapped children learned faster and functioned better if they were given preschool education. He epitomized a delightful combination of munchkin and the good witch of the West as he pointed us down the yellow brick road to a wonderful world where all would be better for handicapped children. He made no promises beyond what his research implied, but we, like Dorothy, knew that when we got to Oz all our wishes would be given us.

And, fortunately, the great white palace on the Potomac was occupied by a succession of witches of the East who smiled with favor upon those who were traveling the yellow brick road and heaped resources upon them. Yet, despite some gallant knights and even a few ogres who denounced early childhood education because there were no data to support its long range effectiveness, no demand for such data came from the friendly witches of the East in the great white palace nor from the sorcerers who administered the witch's money for early education. The sages and the merchants who hawked early childhood education kept providing data that a handicapped child in an early childhood pro-

gram would learn more than a similarly handicapped child not receiving such an education. Many were demonstrating that, but that was not the right question. The question that needed to be answered was: What were the long range effects of early childhood education? or What difference did it make to the handicapped child who was nine years old - 12 years old - 15 years old if he did or did not have a preschool educational experience?

A few of the sages and the merchants began to become concerned about that question and some even performed some research and gathered some data, and these became well known, but were few in number.

Then suddenly everything changed. A new witch occupied the great white palace on the Potomac and he announced that he could no longer provide assistance like the former witches. Data might make a difference but, alas, there was not as much data as was needed . . . . And thus, there was proposed that the support and resources for early childhood education be reduced and the sages and merchants were sad and disheartened.

The Practitioner Today

Please excuse the little analogy between the Wizard of Oz and our current situation in early childhood. I use it merely to emphasize the importance that data can have on the preservation of programs for the handicapped. Those data to demonstrate effectiveness should be gathered not only by the so-called researchers and by the universities but also by those who conduct early childhood programs. These data should focus on the long range effects of early childhood education, for that is the essence of what must be proved - that early childhood education does make a difference in the child's later growth and development.

There are a number of questions that practitioners could try to answer:

1. How do children who were in my program compare with children who did not receive an early childhood education in the areas of:

   a. socialization
   b. receptive language
   c. expressive language
   d. cognitive (academic)
   e. self-help
   f. motor

at age:

a. 8 years b. 9 years c. 10 years

(A practitioner could focus only one of the above.)

2. How many children who were in my program were later institutionalized as compared to a non-early instruction group? How much public money was saved because of less institutional referrals?
3. How many children who were in my program were later referred to special education programs as compared to a non-early intervention group? How much public money was saved because of less referrals?
4. How many children in my program were referred to a lesser restrictive environment as compared to a non-early intervention group? How much money was saved because of this type of placement?

This type of information then should be shared with fellow professionals through journal articles and at conventions. Equally as important, that information should be shared with state and federal bureaucrats who are either responsible or potentially responsible for the administration of such programs. Finally, state and federal legislators should be sent copies of abstracts of the papers so that they too may be continually reminded of the importance of early childhood programs.

An Example of a Study

Let me now share with you the results of one such study:

Introduction The Teaching Research Infant and Child Center recently completed a study to determine the long range effects of early childhood education on a developmentally disabled population. The results of part of that study are reported herein - the part that focused on this question: To what extent are the benefits of a preschool experience maintained one or more years following that preschool experience? The ideal approach to provide an answer to that question is through experimental research design. However, the use of experimental designs to obtain longitudinal data for the analysis of program impact is costly in both time and financial resources. A viable alternative to long

term costs involved with the more controlled research designs is the use of ex post facto research. This is the approach used in this study.

Methods. Beginning in Spring, 1974 and continuing through to the present time, all preschool and school age children in Oregon who were in trainable mentally retarded (TMR) programs funded by the Oregon Mental Health Division had been given, on a pretest-posttest basis, a criterion referenced inventory of skill development. Data which had been collected as a result of administering that instrument over the years had been computerized at the University of Oregon computation center. That instrument, the Student Progress Record (SPR), is composed of 13 subtests: receptive language, expressive language, motor skills, social skills, reading, writing, number concepts, money, time, eating, dressing, personal hygiene, and physical fitness. Annual data were reported for each child in each TMR classroom in Oregon on each of the 13 subtests. Inter-rater and test-retest reliability data on the SPR have been collected over the years using the Oregon State Mental Health Division staff for obtaining reliability coefficients with the individual classroom teachers across the state. Overall reliabilities consistently remained above 90% during the years for both inter-rater and test-retest comparisons.

Oregon, thus, has had continuous data to track TMR children across at least three successive years. Data were, thus, available for children who had completed a preschool experience, as well as for those who had not enrolled in a preschool program. Children chosen for the study were divided into three groups: 1) those who had no preschool, 2) those who had one year of preschool and 3) those who had two or more years of preschool.

A total of 1276 children enrolled in TMR classrooms in the state of Oregon were administered the SPR. Of these 1276, a total of 151 children between 90 and 145 months of age and had been administered the SPR over three consecutive Springs and thus became the subjects for the post hoc analysis of skill acquisition over that three year period. Table 1 shows distribution of children.

**Table 1**

**Distribution of Sample Children Across Years of Preschool and Age Groups**

| Age Group (in months) | Years of Preschool 0 | 1 | 2 | Total |
|---|---|---|---|---|
| 90 - 109 | 22 | 11 | 19 | 52 |
| 110 - 127 | 21 | 12 | 17 | 50 |
| 128 - 145 | 25 | 12 | 12 | 49 |
| **TOTALS** | **68** | **35** | **48** | **151** |

The level of each child's handicapping condition was indicated by the child's current teacher, based upon formal diagnostic results and/or general level of behavioral functioning. The four areas of handicapping conditions included level or degree of: mental retardation, motor dysfunction, hearing impairment, and visual impairment. The scale on which the teacher rated the children for degree of retardation was similar to the classification system used by the American Association of Mental Deficiency (Grossman, 1977): 6 = profound, 5 = severe, 4 = moderate, 3 = mild, 2 = border line, and 1 = none. For the motor, hearing and visual areas, the following scale was used for rating: 3 = severe, 2 = mild, and 1 = none.

Table 2 reveals that most of the children were classified as moderately to severely retarded with mild or no additional motor, hearing or visual impairment. The three age groups were not observed to be significantly different from one another on any of the four handicapping conditions.

**Table 2**

**Means and Standard Deviations of Chronological Ages and Handicapping Condition for Age Groups**

| Age Groups | CA | MR | MD | HI | VI |
|---|---|---|---|---|---|
| 9-Year-Olds (n=52) x | 103.6 | 4.365 | 1.538 | 1.154 | 1.019 |
| (Up to 109 mos.) SD | 6.243 | .658 | .609 | .500 | .370 |
| 10-Year-Olds (n=50) x | 119.8 | 4.300 | 1.560 | 1.340 | 1.120 |
| (110-127 mos.) SD | 5.566 | .931 | .760 | .479 | .328 |
| 11-Year-Olds (n=49) x | 133.9 | 4.429 | 1.735 | 1.163 | 1.122 |
| (128-145 mos.) SD | 3.791 | .816 | .785 | .553 | .484 |

Table 3 presents similar chronological age and handicapping condition data for the 151 children across the no-, one- and two-years-of-preschool groups.

Again, no significant differences were observed across age or handicapping conditions for the three levels of the preschool factor.

**Table 3**

**Means and Standard Deviations of Chronological Age and Handicapping Conditions for No- and Pre-School Groups**

| | CA | MR | MD | HI | VI |
|---|---|---|---|---|---|
| 0 Years (n=68) x | 120.5 | 4.338 | 1.809 | 1.221 | 1.118 |
| SD | 12.452 | .908 | .833 | .542 | .474 |
| 1 Years (n=35) x | 118.5 | 4.543 | 1.486 | 1.086 | 1.029 |
| SD | 15.219 | .701 | .612 | .445 | .382 |
| 2 Years (N=48) x | 116.5 | 4.271 | 1.417 | 1.313 | 1.083 |
| SD | 13.618 | .707 | .539 | .512 | .279 |

The 13 individually measured areas of the SPR were consolidated into five composite areas by combining the 13 specific areas into more traditional major curricular areas for TMR programs. The five curricular areas, with subsumed composite areas, are as follows: social (social); language (receptive language and expressive language); academics (number concepts, money, reading, writing, and time); self-help (eating, dressing and personal hygiene); motor (gross and fine). The results from the five major curricular areas were then available for analysis across three successive years of SPR administration Spring, 1975, Spring, 1976 and Spring, 1977 ($T_1$, $T_2$ and $T_3$ respectively).

Results

Social. There were no significant differences in socialization scores between non-preschool and preschool groups. As measured by the SPR, then, whether a child was enrolled in a preschool program or not, had little measured effect on that child's level of socialization skills.

Figure 1 presents the plotted cell means for the social scores over the three Spring administrations ($T_1$, $T_2$, and $T_3$) of the SPR. It is interesting to note that over the three consecutive years for which SPR data were available, there is a tendency although not significantly so ($p. = .07$ for combined scores) for those children who were enrolled in a preschool program for two years or more to score consistently higher than both the 0- and 1-year-of-preschool groups. Moreover, those differences tend to increase the longer those children have been in school age programs.

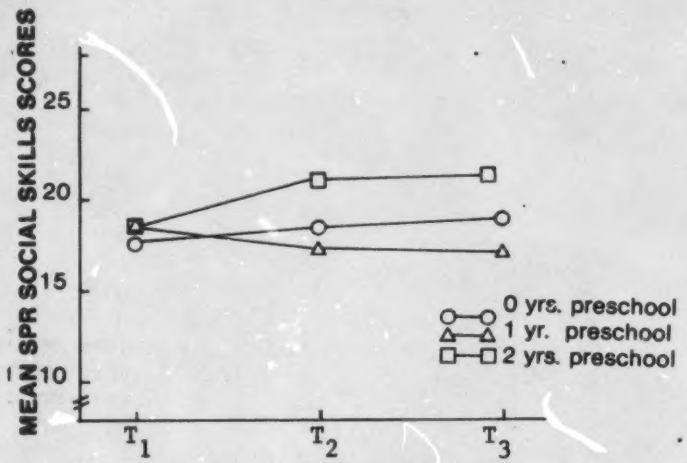


**Figure 1.**
**Mean social scores for preschool across time.**

Language. Measurement of language scores over time indicated significant differences (p = .02) between those with two or more years of preschool and those with no preschool. The differences in language scores were not significant (p. = .09) between those with no preschool and those with one year of preschool. See Figure 2.

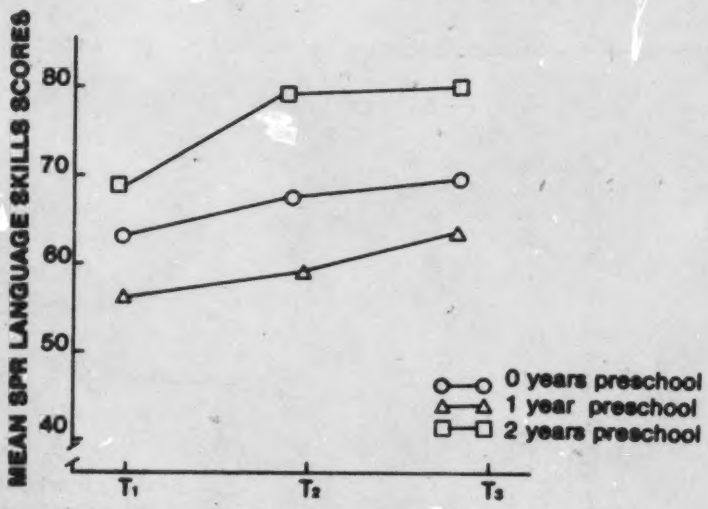


**Figure 2.**
**Language Scores Over Time**

Academics. Measurement of academic skill scores over time, considering combined scores, indicate significant differences (.03) between those with two years of preschool and those with no preschool year. There were no significant differences between those with one year of preschool and those with no

years of preschool. See Figure 3.

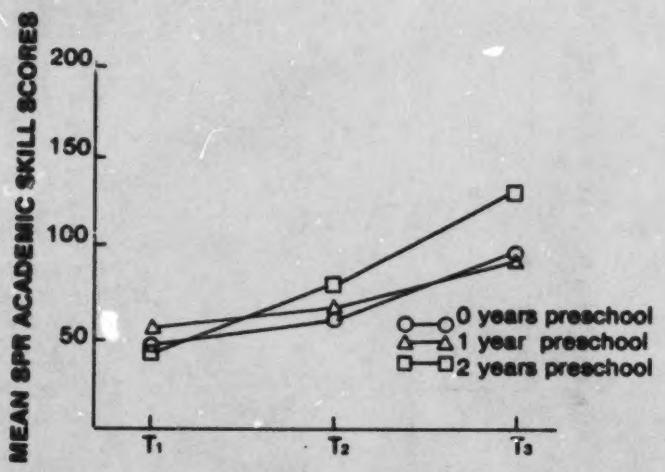


**Figure 3.**
**Mean academic scores for preschool and CA groups across time.**

Self-Help. Measurement of self-help skills over time, considering combined scores, indicate significant differences (.01) between those with two years of preschool and those with one or no years of preschool. There were no significant differences between those with one year of preschool and those with no preschool time (see Figure 4).

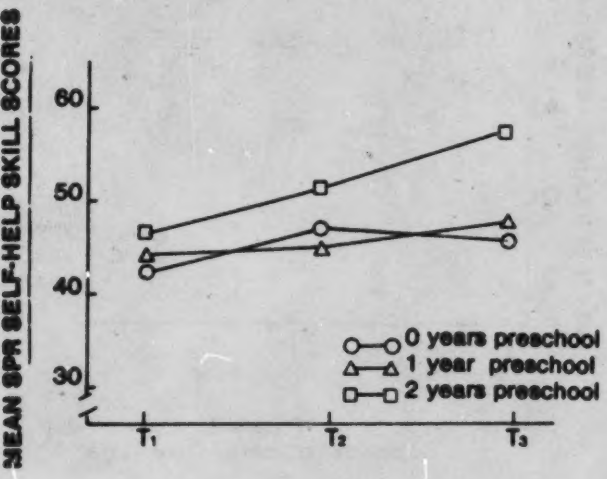


**Figure 4.**
**Self-help over time.**

Motor. Measurement of motor skills over time, considering combined scores, indicate significant differences (.03) between those with two years

of preschool and those with no preschool. The difference between those with one year of preschool and those with no years of preschool is non-significant ($p = .20$) (see Figure 5).

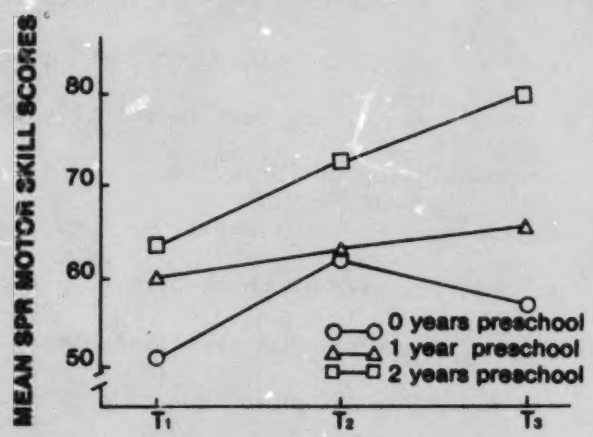


**Figure 5.**
**Mean motor scores for preschool and CA groups across time.**

Taken collectively, the results for the five curricular areas (social, language, academic, self-help, and motor) support the contention that a preschool experience does influence skill development, and that the results of that preschool experience are maintained over time. Those children who had been enrolled in a preschool program for two years performed significantly better than children not enrolled in preschool in the adademic areas of language, academics, self-help, and motor. Although not significant, the same trend was noted in the social curricular area. The same types of differences were not demonstrated between those who attended preschool for one year and those who did not attend preschool.

Another factor needs to be considered when examining these data; a factor that may indicate that the data are conservative. A survey was conducted of every school district which contained TMR classes, Eighty-eight percent of the school districts containing such classes responded to a questionnaire. They were asked to identify TMR children who had been moved from TMR classes in the past four years to other programs such as resource centers, EMR classes or regular classes. They were further asked to indicate the number of years

of preschool education which the transferred child had. One hundred thirty-one children were so identified. All but 11 had had at least one year of preschool experience. Ninety-four of the children had two or more years of preschool. Consequently, the higher functioning children graduating from preschool developmental disabilities programs and into less restrictive environments are likely removing the higher functioning children from the preschool experienced samples. Thus, the overall degree of differential performance of the children who have had the preschool, compared to those with no preschool experience, is surely reduced. Had the children who had previously been in a preschool program and then placed in a less restrictive educational environment, also been administered the SPR while in those less restrictive environments, differences reported in the current study may have been more pronounced. This study suffers because of that lack of data.

Summary

We have presented to you one example of a long range study for early childhood education. It is only one piece of evidence. More evidence of the effectiveness of early education is necessary. Once again, let me encourage you to help gather that information so that if ever again the occupants of the great white palace on the Potomac choose to withdraw support from programs for the handicapped, we shall not be found wanting, but will be able to counter such proposals with solid evidence that the programs we expose are not only educationally beneficial but also are cost beneficial.

# THE COUNTRY CHILDREN

## WHO SERVES THEM AND HOW

Bud Fredericks, ED. D. — Teaching Research
Research Professor — Monmouth, Oregon

### Introduction

It is a well-known fact that handicapped children are frequently isolates. Because of their handicapping condition, they do not make friends easily with non-handicapped children and find themselves in a naturally isolated situation. The parents of handicapped children also have that sensation. They feel as though they are alone with their problems and thus frequently they seek out the company of other such parents to share thoughts about raising their child, to share their anxieties, their concerns, and their frustrations.

A handicapped child who resides in the country is isolated in a much broader sense in that not only does he have the natural isolation of being handicapped, but also because of the sparse population, he may be the only handicapped child in the area. Consequently, it is frequently difficult to organize classrooms or educational facilities that will service this child adequately.

The purpose of this talk today is to share with you two methods by which such children can be served. One of these is known as the rural aide model. The other is a system of parent training which is especially appropriate for rural populations.

### Rural Aide Program

The rural aide model that we shall describe is the one that is used in the state of Oregon for its developmentally disabled population. These are in TMR classes. (In Oregon TMR includes any child in the moderate, severe or profound range of handicapping conditions.) As previously indicated, this is a relatively low incidence population and consequently, many smaller communtities during the early 1970s were finding it difficult to establish self-contained,

yet age appropriate, services for students. In an effort to resolve this problem, the MR/DD Program Office of the Mental Health Division of the State of Oregon funded a number of rural model aides. These aides are assigned to work with no more than three moderately severely or profoundly handicapped students. The students may be placed in regular classrooms, education resource centers or a classroom for the educable mentally retarded. The aide must work under the direct supervision of the certified teacher.

Each of these aides are trained in curriculum, individual programming, behavior management and coordination with parents. The Mental Health Division in the state systematically provides for this training.

The greatest concern with the model were questions about the service quality or educational effectiveness. In an effort to answer this question, a data review was conducted and the following were determined. The student progress data as measured by the student progress record, was reviewed in 1978 for 1,752 TMR students (moderate, severe and profound) of all ages. Eighty-three students were in rural model aide programs. One thousand, one hundred and fifty-two were in community based, public school, TMR classrooms. One hundred twenty-three were in private TMR programs and 394 were served in institutional settings.

Gain scores for each student were calculated in each of the 14 curricula areas measured by the SPR. These gain scores were the performance difference between the fall pretest and the spring posttest. Results indicated that even when tampered by the cautions inherent in doing such a data review, that TMR rural aide program was as effective in developing student gains as were community based TMR classrooms. They were also significantly more effective than were the institutional programs. Although this review must be reviewed with caution and with consideration for many variables, it remains a strong indicator that the rural model aide program is educationally effective.

It certainly is a model that can be adopted by other states with rural populations for serving not only their preschool handicapped population but all moderately, severely handicapped populations in country settings.

Parent Training

The other system which the state of Oregon has established to serve parents operated across both rural and populous areas. Parent training in the state of Oregon is established on a statewide basis. Parent trainers are found in 21 of the 36 counties in Oregon and plans are extant to expand that network as resources become available. The parent training model is based upon the concept of parents of handicapped children being served by a trainer who teaches the parents necessary skills which will help them to teach their child communication skills, motor development, self help, and cognitive skills in addition to behavior management. The parent training network focuses primarily on the 0-3 population although it also serves an older population as needed. The network has been in operation now for seven years and has been found to be quite effective. The following data will demonstrate its effectiveness.

Table 1 provides a summary of the results of the prescriptive programming for the entire state for the period of the report. A total of 726 children were served, with 72% of them being identified as DD/TMR/EMR and 28% of them being identified as having behavior problems. Fifty-six per cent of the children were in the age range 0-6 which is in the priority age range for service as set by the Mental Health Division.

In reviewing the data from the program areas, it can be noted that 50% of all programs written were in the behavioral area. This certainly emphasizes the parental concern for dealing with the social behavior problems of their children regardless of their being identified as handicapped or non handicapped.

Eighty one percent (81%) of the programs were successfully terminated and 19% were unsuccessfully terminated. Considering the variety of programs written and the diversity of children served, these results are quite good.

Table 2 presents data summarizing the unsuccessfully terminated programs. Sixty four or 12% of the total families who had DD/TMR/EMR children had unsuccessfully terminated programs. Thirty-two or 16% of the total families of behavior problem children had unsuccessfully terminated programs.

| Categories | DD/TMR/EMR | | Behavior Problems | | Total | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| I. Number of Families (Total) | 520 | 72 | 206 | 28 | 726 | 100 |
| A. Terminated | 272 | 52 | 129 | 63 | 401 | 55 |
| B. Families Active | 248 | 48 | 77 | 37 | 325 | 45 |
| II. Children Served by Age (Total) | 520 | 72 | 206 | 28 | 726 | 100 |
| A. 0-6 | 283 | 54 | 125 | 61 | 408 | 56 |
| B. 7-12 | 122 | 23 | 71 | 34 | 193 | 27 |
| C. 13-16 | 65 | 13 | 6 | 3 | 71 | 10 |
| D. 16-Adult | 50 | 10 | 4 | 2 | 54 | 7 |
| III. Number of Programs by Areas (Total) | 2,008 | 78 | 566 | 22 | 2,574 | 100 |
| A. Self Help | 335 | 17 | 70 | 12 | 405 | 16 |
| B. Language | 262 | 13 | 53 | 9 | 315 | 12 |
| C. Behavior | 841 | 42 | 434 | 77 | 1,275 | 50 |
| D. Motor | 417 | 21 | 2 | -- | 419 | 16 |
| E. Academic | 153 | 7 | 7 | 2 | 160 | 6 |
| IV. Status of all Programs (Total) | 2,008 | 78 | 566 | 22 | 2,574 | 100 |
| A. Successfully Terminated | 1,218 | 61 | 352 | 62 | 1,570 | 61 |
| B. Unsuccessfully Terminated | 257 | 13 | 103 | 18 | 360 | 14 |
| C. Ongoing 6/30/79 | 533 | 26 | 111 | 20 | 644 | 25 |
| V. Status of Terminated Programs (Total) | 1,475 | 77 | 455 | 23 | 1,930 | 100 |
| A. Successfully Terminated | 1,218 | 83 | 352 | 77 | 1,570 | 81 |
| B. Unsuccessfully Terminated | 257 | 17 | 103 | 23 | 360 | 19 |
| VI. Number of Programs by Child | 3.86 | -- | 2.75 | -- | 3.31 | -- |







TABLE I

Oregon Statewide Parent Training Network
Prescriptive Program Data
(July 1, 1977 - June 30, 1979)

TABLE 2

Unsuccessfully Terminated Program Data

Parent Training Network
(July 1, 1977 - June 30, 1979)

| Program Data | DD/TMR/EMR | | Behavior | | Total | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| Programs Unsuccessfully Terminated | 257 | 71 | 103 | 29 | 360 | 100 |
| Families Involved | 64 | 67 | 32 | 33 | 96 | 100 |
| Reason for Termination | | | | | | |
| Moved | 136 | 52 | 63 | 61 | 199 | 55 |
| Medical Problems | 22 | 8 | 2 | 2 | 24 | 7 |
| Child Removed from Family | 2 | 1 | -- | -- | 2 | 1 |
| Family Dissatisfaction | 10 | 4 | -- | -- | 10 | 3 |
| Family Satisfied with Progress | 16 | 6 | 22 | 21 | 38 | 10 |
| Child Placed in School | 48 | 19 | 5 | 5 | 53 | 14 |
| Child Institutionalized | 2 | 1 | -- | -- | 2 | 1 |
| Foster Placement | 12 | 5 | 9 | 9 | 21 | 6 |
| Unknown | 9 | 4 | 2 | 2 | 11 | 3 |

The major reason that programs were terminated unsuccessfully across all groups of families was that they moved before the program goals were met. Moving accounted for 55% of the unsuccessful terminations.

An interesting set of data are those that indicate that the families terminated programs because they were satisfied with the progress the child was making even though the terminal goal had not been met. Sixteen programs were terminated in the DD/TMR/EMR group for this reason, and twenty-two from the behavior problem group for this reason. These data indicate that as the child improved, the parents became aware of the improvement and they felt they were satisfied with the level of performance the child was exhibiting even though the program goal had not been attained. Needless to say, all of these programs were social behavior programs.

Another interesting set of data are those which indicate family dissatisfaction. Ten programs or 3% of those unsuccessfully terminated (3% of <u>all</u> programs) fell into this categor . Add to these the 11 terminated for unknown reasons, assuming that they may be also terminated for dissatisfaction, and a total of 8% of cases <u>may be</u> dissatisfied.

As set by the State Mental Health Division, the case load for a full-time parent trainer is approximately 20 families while the case load for a ha f-time parent trainer is 10 families. During the two year period of this report, there were 726 families served in 20 sites for an average of 3 families per site for two years or 18 families per year.

<u>Summary</u>

In this talk, I have tried to emphasize that handicapped children in rural settings may tend to be more isolated than such children in more populous areas. Moreover, their parents also need support and advice regarding their handicapped child. Other parents of handicapped children are usually not available to provide this support. To provide for both the child and the parent, two educational models have been discussed - the rural aide model which has been found to be effective for handicapped children of all ages and the parent training network,

as established in the state of Oregon.

HOW TO TELL WHO YOU'RE TEACHING

WITHOUT A LABEL

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PRINCIPAL INVESTIGATOR, WESTAR

# HOW TO TELL WHO YOU'RE TEACHING WITHOUT A LABEL

Norris G. Haring, Ed. D. University of Washington

Labeling is like sinning, we know we shouldn't do it, but we do it anyway. Our discipline has played an important role in labeling, some are our own - however, many have been borrowed from the field of medicine due to the unusual fascination we seem to have with medical terminology.

## Prevailing Systems for Classifying the Exceptional

### Definitions

Keeping in mind that any definition of exceptionality or any system for classifying subcategories of exceptionality reflects the values of a particular society, let us consider some of the current definitions that are influential in the field of special education.

Dunn's most recent definition focuses on the exceptional pupil and his educational needs.

> An exceptional pupil is so labeled only for that segment of his school career (1) when his deviating physical or behavioral characteristics are of such a nature as to manifest a significant learning asset or disability for special education purposes; and, therefore, (2) when, through trial provisions, it has been determined that he can make greater all-round adjustment and scholastic progress with direct or indirect special education services than he could with only a typical regular school program (1973:7).

Kirk's definition also focuses on the educational needs of exceptional children with the additional feature that he outlines numerous subcategories of exceptionality.

> The exceptional child is defined as the child who deviates from the average or normal child (1) in mental characteristics, (2) in sensory abilities, (3) in neuromuscular or physical characteristics, (4) in social or emotional behavior, (5) in communication abilities, (5) in multiple handicaps to such an extent that he requires a modification of school practices, or special educational services, or order to develop to his maximum capacity (1972:4).

P.L. 94-142, the landmark bill mandating services for the handicapped provides

a definition of 'handicapped children' which is a useful legal referent.

Sec. 121a.5 Handicapped children

(a) As used in this part, the term 'handicapped children' means those children evaluated in accordance with 121a.530-121a.534 as being mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, multi-handicapped, or as having specific learning disabilities, who because of those impairments need special educational and related services.

For the sake of simplicity, exceptional people can be defined as those individuals who differ significantly in what they need to succeed in the world. They are individuals with special needs.

## Categories of Exceptionality

In general, exceptional children are those having one or more of the following.

1. Sensory handicaps, including children with hearing and vision impairments.
2. Mental deviations, including the gifted as well as the mentally retarded.
3. Communication disorders, such as speech and language disorders.
4. Learning disabilities.
5. Behavior disorders.
6. Physical disabilities such as orthopedic conditions and neurological disorders.
7. Health impairments including diseases such as sickle cell anemia and muscular dystrophy.

## Problems of Labeling

While some system for identifying and classifying people with special needs is the first step toward providing services to meet these needs, the danger involved in singling out any person as a deviant has come under increasing scrutiny. In 1972, Elliot Richardson, then Secretary of Health, Education, and Welfare, urged federal agencies to review the system for classification and labeling of exceptional children. As a result, the Project on the Classification of Exceptional Children was begun. It culminated in the two volune study entitled Issues in Classification of Children: A Sourcebook on Categories, Labels and Their Conse-

quences edited by Nicholas Hobbs (1975:vii-viii). It was this study that set forth in clearest detail the multiple facets to the issue of classification in special education.

## Advantages of Labeling

The invention of a label can result in increased visibility for a group of people who have special needs. A good example of this is the case mentioned earlier of the invention of the label "Learning Disabled". At the same convention at which this term was introduced, parents who were eager for a more euphamistic term for their learning delayed children formed the Association for Children with Learning Disabilities. This association now has chapters in all 50 states and has proven itself an effective special interest group in lobbying for legislation, federal funding and special programs for the learning disabled.

Besides being useful in rallying support and funding, labels have also proved to be administratively useful in organizing children in the school system. A common argument in their favor is that some system of classification is necessary if special education services are to be organized efficiently.

Finally, those who favor the use of labels have argued that they are diagnostically sound and contribute to the identification of useful approaches to treatment.

## Arguments Against the Present System of Labeling

The assumption that labels are accurate and contribute to defining the special services that are needed has come under attack. Reger, Schroders and Uschold state:

> We are saying that grouping children on the basis of medically derived labels has no practical utility in the schools. Children should be grouped on the basis of their educational needs, and these needs may be defined in any number of ways. The notion that simple labels, applied by high status authorities from outside the school, should serve as a basis for grouping children is basically nothing more than a refusal to accept responsibility for making educational decisions. It is educational laziness (1968).

Hobbs asserted that systems of classification should be designed to:

> deemphasize the familiar but gross categories of exceptionality. It should specify instead the services required to assist the child or his family and school in the interest of the child's fullest development (1975:234).

He warned against the danger of applying any system of classification, especially those that are of little direct relevence to the educational needs of the exceptional person.

> Classification, or inappropriate classification . . .can blight the life of a child, reducing opportunity, diminishing his competence and self-esteem, alienating him from others, nurturing a meanness of spirit, and making him less a person than he could become. Nothing less than the futures of children is at stake (1975:1).

Gallagher has charged that labels are often used to fill "a need for closure on a difficult diagnostic issue" (1976:3). Labels such as minimal brain dysfunction or autism do not convey any precise notion of etiology or of cure. They do not tell a teacher how to set about designing a course of instruction. They are not, in short, educationally useful.

The issue of the educational utility of the current system of labeling is addressed in the Hobbs study in an article by Goldstein, Arkell, Ashcroft, Hurly and Lilly.

> . . .Although some might agree that present systems for classifying handicapped children in the public schools have some value to administration in that they provide pegs upon which funding and management procedures can be hung, their value to the educational enterprises is less pronounced. Their limited relationship to teaching/learning activities, along with their ambiguities, makes possible educational practices that are unproductive and frequently unjust. To put it another way, they give minimum direction in decision making about day-to-day instructional needs of children; at the same time, they permit children who require interventions other than those typical of special education to be sidetracked into these classes (1975:55).

Arguments against the use of the current semi-prerogative labels such as "behaviorally disordered" point to the ambiguity that characterize the criteria for many of the categories of exceptionality. Not only is there disagreement over the typical characteristics manifested by a child who is, for example, labeled "learning disabled" but within the category of the learning disabled there is a wide range of individual differences. To know that a child is learning disabled is not to know either the etiology of his/her problem, the nature of his/her symp-

toms or the remedial services necessary to assist the child. In fact, it is argued, broad and ill-defined terms such as "learning disabled" do more to obscure important aspects of an individual's problem than they do to facilitate understanding and treatment. There is a tendency to minimize individual differences within a group of labeled persons and to assume that everyone grouped under a particular label should be segregated and treated in a similar way.

Another and equally unsavory side effect of labeling is the effect it has on the person who is labeled. With the pressure for conformity among school aged peers already intense, it is painful to be different no matter how minor the difference. To be labeled "behaviorally disordered" or worse still, "mentally retarded", is to be branded. Social ostracism and feelings of shame and inferiority accompany such labeling even though, at the administrative level, such labels are useful and lead to special services.

An important aspect of the skewing of perceptions of the labeled person is the over-emphasis in the current labeling system on the deviant aspects of a person. These aspects are given quasi-medical terms such as "behavioral disorder" which give an aura of seriousness and permanence to the problem. Noticeably lacking is the sense of relationship of the deviant characteristics to the totality of the person and to the contextual factors that influence the manifestation of the symptoms of the problem. Thus, when Johnny is not making progress in his school work, he may be referred to as "learning disabled" rather than described in more holistic terms such as "Johnny is inattentive and discontent in X's class and is making little progress." While the latter description is more awkward than a label, it is a more accurate description of Johnny as a person. Such an approach takes a contextual, interactional view of the 'problem' instead of viewing it as a 'disorder' that is self-contained within the person. The onus is then on the teacher and on the school to analyze the 'problem' of Johnny's behavior in the classroom rather than to pack Johnny off to a special class for the learning disabled.

Finally, the sharpest and most vocal critics of the classification system and of the standardized testing procedures used to idendify the 'exceptional' have been the parents of minority children.

Disturbing statistics are now being compiled which unequivocably show that a disproportionate number of minority children have been placed in segregated special education classes. Meyen writes that:

> Jones and Wilderson (1976), in examining Mercer's data, analyzed the relationship of placement of Anglos, blacks, and Mexican-Americans; they found that black children were 7 times as likely and Mexican-American children 10 times as likely as Anglo children to be placed in special classes (1978:72).

Johnson has charged that:

> Special education is part of the arrangement for cooling out students. It has helped to erect a parellel system which permits relief of institutional guilt and humilation stemming from the failure to achieve competence and effectiveness in the task given to it by society. Special education is helping the regular school maintain its spoiled identity when it creates special programs (whether psychodynamic or behavioral modification) for the "disruptive child" and the 'slow learner', many of whom, for some strange reason, happen to be black and poor and live in the inner city (1969:245).

Conversely, minority children are grossly underreprensented in special programs for the gifted. This is due in large part to the use of culturally biased IQ tests to qualify students as 'gifted'.

Perhaps the most troubling criticism of the use of current labels is the danger that labels may predict or actually shape limitations or failure for a child - the so-called 'Pygmalion effect' (Rosenthal and Jacobson, 1968). In this study, two researchers assigned children to one of two categories: slow and late bloomers. Teachers were told that the "slow" children might never catch up, while the "late bloomers" would. And this is just what happened, even though the groups were really no different from one another at the start of the study. Though the adequacy of the experimental procedures has been criticized (Elashoff & Snow, 1971), other studies support the notion that, to some degree at least, children will perform as their teachers expect them to perform (Beez, 1969; Fine, 1970).

A comparison of these classification problems is presented in the following chart.

| BASIC PREMISES OF CLASSIFICATION | PROBLEMS WITH PRESENT SYSTEM |
|---|---|
| Provides communication device among professionals | Provides misleading and inaccurate information |
| Provides benefits to classified individual | Classification more beneficial to classifier than classified |
| Allows classified individual the opportunity for special programming | Educational categories being used (ED, MR, LD) are not programmatically specific enough to be of any real benefit in programming. Present system categorizes permanent or chronic conditions. Individuals with transient problems are denied individualized educational opportunities |
| Provides data to aid in correcting or modifying condition described | Does little to enhance the selection of type of treatment to correct the problem.<br>There are no unique educational (teaching/learning) processes to be used according to labels designated |
| Helps identify the child's problems | Ignores the interactive nature of the child and his environment; implies causation within the child |
| Helps others put the unusual behavior into perspective and results in greater acceptance. | Acceptance generally quicker but promotes acceptance as an inferior rather than an equal<br>Conditional acceptance leads to lower expectations that can result in poorer performance of the labelled individual |
| Promotes monetary appropriations | Monetary appropriations can not offset the dehumanizing effect of the labels used |

## Trends in the Perception and Labeling of the Exceptional

Educators are now more enlightened about the role of cultural and historical factors in the perception of the exceptional. The recent focus on the problems inherent in our present system of classification coupled by more strident demands to protect the civil rights of the handicapped have resulted in an active concern to overhaul the classification system. Instead of falling back on the excuse that labels are necessary in order to lobby for legislation and obtain fund-

ing, there is increased interest in changing legislation and funding procedures that require the use of labels. Concern is being shown with designing a flexible system of funding which provides funds for the education of every person whatever his particular need. This system would focus on grouping people according to their educational need rather than their particular handicaps or gifts.

Court decisions such as Larry P. v. Riles which prohibited the use of IQ tests with handicapped children may have the effect of curtailing the current enthusiasm for the statistical definition of 'normality'. The end result, it is hoped, will be a greater emphasis in the schools on domain referenced tests that test an individual's skills in a particular content area. A focus on particular skill levels and on the educational task at hand will hopefully defuse the over zealous concern with identifying those who are normal and not-normal and redirect energy toward working with each person according to his/her need.

Ultimately such a shift in emphasis will mean a relaxation of our popular notions of 'normality'. There will be less of an emphasis on conformity and more of an emphasis on expanding the category of 'normality' to accommodate people with a wide range of individual differences. This will necessitate innovations in classroom instruction to allow for more individual instruction.

If you don't label the child then it is necessary to label the SERVICES the child needs. There are special intervention strategies that we use for special identified problems. For example, when characteristics of Learning Disabilities have been identified, we note:

1) The individual acquires information at a slower rate and with less reliability
2) The student doesn't retain either short-term or long-term information.
3) The individual has difficulty generalizing skills and information.

Once the characteristics have been identified, we then label the SPECIAL SERVICE that the child requires. For example, we need to:

1) Individualize the program and pay particular attention to instructional cues.
2) Measure performance almost daily to assure changes made in instructional programs are improving the child's acquisition. 36

With children who have memory or retention deficits, we need to do the first two steps as noted previously:

1) Develop individual instruction

2) Perform regular measurement

and in ADDITION:

3) Provide increased opportunity for the child to recite and/or practice

4) WITH THAT, there is a need to establish novel ways and settings for him/her to recite in (for associations). More opportunity - More settings - More novelty.

Children with generalization deficits can perform in a training setting but not in natural setting. With these children, we do two things:

1) Provide cues normally used in the training setting in the natural setting.

2) Teach the child the principle in order to strengthen the response-generalization.

By incorporating these and other appropriate methods in a program, we have LABELED the INTERVENTION STRATEGY without labeling the child.

| LABEL | OBSERVED BEHAVIOR | INSTRUCTIONAL INTERVENTIONS |
|---|---|---|
| Learning Disability | Deficits in acquiring, retaining, acquisition, retention and generalizing skills | 1. Individualized instructional programs<br>2. Refine instructional program form a systematic record of performance<br>3. Provide guided opportunities for performing in alternate settings |
| Emotional and Social Disorders | Inappropriate social, self injurious, and disruptive behaviors | All of the above plus<br>4. Provide positive social consequences for appropriate behaviors and punitive consequences for inappropriate behavior |
| Visually Impaired | Deficits in responding to visual stimuli | All of the above plus<br>5. Utilize fully the residual vision. Provide alternate sources of information. Provide interventions |
| Hearing Impaired | Deficits in responding to auditory stimuli | 1, 2, 3, 4, above plus<br>6. Utilize fully the residual hearing and provide alternate sources of information<br>7. Develop total language including American Sign Language<br>8. If total language development is not possible, utilize alternate forms of communication |
| Physically Handicapped | Response deficits in fine and gross motor coordination | Provide 1, 2, 3, 4, & 5 above plus<br>9. Provide individualized prostheses<br>10. Modify environment to enable mobility |

# COMPONENTS OF AN EXEMPLARY PROGRAM

# FOR YOUNG HANDICAPPED CHILDREN

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# COMPONENTS OF AN EXEMPLARY PROGRAM

# FOR YOUNG HANDICAPPED CHILDREN

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Over thirty odd years in the teaching profession, I have observed that certain characteristics set exemplary programs apart from those that are poor or mediocre. Educational research has reinforced some of these impressions, but where research findings are lacking, I have drawn from the writing of those I consider to be experts in the field to validate or refute my ideas. In this paper, then, I will review program characteristics that I feel ensure optimal child growth. It must, of course, be acknowledged at the outset that all of these characteristics are not present in all exemplary programs to the same degree; all of them, however, are generally found in programs of excellence. I will make no attempt to introduce these characteristics in order of importance.

## Administrative Leadership

Administrative leadership that encourages, supports, and reinforces the efforts of the staff results in good morale. Staff members under such conditions are, as a rule, enthusiastic, energetic, resourceful and creative. They are committed to children and continue to seek new and better ways of promoting child progress. These attitudes and behaviors are manifested partially because the administration selects persons with such attributes but largely because it encourages and reinforces such attributes.

Leaders set the stage for those they supervise. If they expect quality programs, staff members usually rally to these expectations. We know that children reflect the attitudes of the significant adults in their lives, and it is not surprising to observe that staff members reflect the attitudes of administrators and supervisors.

The quality of administrative leadership can be assessed at least in part

by examining the budget, considering the provisions for professional growth of staff, by determining the adequacy of the physical facilities, and by evaluating how the program is monitored. Finally, the attitude of staff, parents, and community members toward the program is closely related to administrative leadership.

Strong leadership generally receives strong public support, and such support is essential in ensuring the financial basis of the program. It is difficult to develop an exemplary program when staff can not be assured from year to year that resources will be available to finance an ongoing program. A weak financial structure breeds anxiety among staff and parents. To function effectively, the staff must feel that their positions are secure and that they will be provided with the necessary materials, equipment and space to offer children the instructional program and services they need. Programs built on an unstable financial basis often experience high staff turnover and low staff morale--conditions that are not compatible with quality service.

Teacher Concerns

While administrative leadership is paramount to quality programs, the success or failure of any classroom program rests with the teacher. Much has been written about the competencies of teachers in terms of professional skills and about the effect of their personalities and behaviors on child progress. I will first discuss the self-concept of the teacher and its effect on children; then I will consider professional behaviors which have a bearing on the intellectual, academic, and social growth of children, particularly fostering language development, programming according to learning styles, offering positive reinforcement, enhancing the self-concept of the child, providing for affective development, and seeking out ways to continue professional growth.

The self-concept of teachers has been studied by a number of researchers. Their findings coupled with logic tell us that teachers must have a positive view of themselves if they are to help children develop positive self-concepts. There are those who argue that the attitudes teachers hold toward themselves and others

may be even more important than the teaching procedures they use. It has generally been found that positive attitudes of the teacher promote a classroom atmosphere conducive to learning while negative attitudes of the teacher tend to foster negative feelings among pupils and to reduce child learning.

No one would argue that good mental health is closely associated with an adequate self-concept. We all have known teachers whose personal problems were so debilitating that they were not fully able to function in the classroom and even negatively influenced the attitude and behavior of their charges. Since a positive self-concept among teachers is so important, more care should be given to selecting teachers with strong self-concepts. Equally important, however, after employment, efforts must be made to sustain and reinforce healthy self-concepts. Here again, the teacher's self-concept seems to be closely related to strong administrative leadership. A strong leader established clear and open communication and a well developed feedback system with those who report to him/her. He/She informs the staff about the quality of its performance and makes clear the value system by which those judgements were made.

The importance of fostering language development is recognized by teachers in all examplary programs, and these teachers specifically provide for the development of language processing skills. Acquiring new concepts and ideas, relating these concepts and ideas in new ways, and communicating them to others are essential skills for all individuals throughout life, but they are of special importance to preschool and school-age pupils. Language is at the very heart of learning and closely related to intellectual functioning. Language correlates highly with academic achievement. Finally, language is the primary means of establishing and maintaining interpersonal relationships; social skills and language development go hand in hand.

Teachers rely on a number of language models when reflecting on language development. One I have found to be highly useful is derived from the clinical model of the Illinois Test of Psycholinguistic Abilities (ITPA). A much oversimplified description of the ITPA model goes like this, Pretend for a moment

that we are computers. A computer is a machine that receives information (input) which may be stored (memory) for later use or processed in some way (organization) Ultimately, what is processed is expressed in some way, such as a tape or paper printout (output). To continue the analogy, we receive information through our senses (reception). Sometimes this information is merely stored or remembered (memory), but at other times partial information may be, in some way, completed for better understanding (closure) or organized into new and different wholes (association). Finally, expression may be verbal or gestural or both.

The input channels most useful in school learning are visual and auditory, seeing and hearing. These are the two included in the ITPA model. This does not mean, of course, that other channels of learning are denied, merely that they are not considered major input channels. Examples of other channels of imput are taste, smell, and touch. In some ways, the division of input and expressive channels in the ITPA may seem artificial and imprecise. Often, we hear and see and touch something simultaneously. When we talk, we often use facial expressions and gestures to express ourselves more fully. The separate parts of the ITPA model are useful, however, in reminding us that language has many facets.

Certain skills must be so highly developed that they can be performed automatically and thus free energy for higher level processes. The acquisition of these skills during the school years is essential if maximum learning is to be achieved. Since language development is cumulative, helping pupils to develop language processing skills must begin at an early age and be programmed throughout the child's school career.

The acquisition of new concepts and ideas is a never-ending process. Children are continuously exposed to new information and are expected to apply it to new situations. The important consideration, here, is that all of us should be able to receive information efficiently, accurately and completely. Mere reception, however, is not in itself sufficient. Relating new information to prior information in meaningful, relevant, and unique ways is critical to the fullest

development of the intellect. Failure to relate ideas effectively results in intellectual functioning far below one's potential.

Communicating facts and concepts that have been received and related is the last step in the language process. A breakdown in this phase interferes with or prevents successful and appropriate interaction with others. On the other hand, pupils who have adequate verbal expressive skills tend to be in command of their behavior and comfortable in interpersonal relationships. Finally, individuals who develop competent language processing skills--reception, relation and transmission--are better able to draw conclusions, to generalize, to make inferences, and to transfer the information and ideas needed to anticipate and plan for the future.

The vast quantity of information received by young learners must be reduced through understanding and practice to the point where it can be utilized automatically. A good example of this reduction process is the automatic use of correct grammar. An individual who must pause to make decisions about what is grammatically correct is unable to focus his attention on the critical activity--the idea being generated. Only when the syntactical components of the language are automatic is he free to use language as a problem-solving tool or as the means of precise communication.

I have developed two programs that make use of an instructional model derived from the clinical model of the ITPA. These curricular units, GOAL I (1972) and GOAL II (1977), assist educators in fostering total language development--acquistion, processing, and transmission--and help them focus selectively on the problem areas of individual children. The importance of scheduling a time in the school day to help children acquire skills in processing information and in communicating with others makes a great deal of sense. In addition, language development skills must be attended to throughout the day, for, like every other skill, language proficiency depends on ample practice.

One of the major strengths in relying on a model such as the ITPA is that the teacher becomes more cognizant of the various facets of language and is more

likely to detect a child's strengths and weaknesses and to provide a balanced program as well as special provisions for special needs. In other words, when the facets of language are clearly delineated, the teacher is less likely to emphasize some areas of language development to the neglect of others. The manuals of the two GOAL units mentioned above offer guidelines for determining strengths and weaknesses of children in the various components of language included in the ITPA model. Through careful, ongoing observation of each child, the teacher can develop an individualized language program by selecting lesson plans appropriate to the language profile of the child. The teacher not only determines each child's strengths and weaknesses in language and programs accordingly but provides daily instruction to promote the development of all areas of language. Those children who have marked deficits in language and speech may need to be referred to a speech and language specialist for diagnosis and special help.

Researchers on language acquisition agree that children enrolled in programs where teachers deliberately set about teaching language processing skills make better progress in language development than do children in programs where teachers leave language development to chance. An exemplary program must be characterized by the teacher's strong emphasis on language development.

Programming to meet individual learning styles is a chief concern of teachers in exemplary programs. Some children learn best in a group while others learn best when they work independently. Some children learn best through the visual channel, and others profit most through a lecture-discussion approach. A teacher who observes children carefully and is committed to individualized programming becomes increasingly aware of each child's style of learning and tries to match at least some activities during the day to each child's preferred learning style.

The importance of individualizing instruction for handicapped children is deemed so critical that United States Public Law 94-142 requires that an individual education program be designed for each handicapped child. Such plans involve long-range goals as well as specific objectives to achieve those goals. While this law focuses on the handicapped, many educators feel that greater pre-

cision in educational planning for the non-handicapped would also be beneficial. It is well documented that homogeneous grouping is virtually a myth, and children can be grouped in only a limited number of ways. No matter how precisely criteria for grouping are followed, the range of individual difference can be reduced only 17 to 20 percent.

Since children differ markedly at any age in interest, rate of learning, goals for learning, capacity to learn, cognitive style, physical stamina, special talents, and presence of and/or severity of handicapping conditions, individualized instruction is essential. Most of the research on individualization of instruction has used elementary age pupils for subjects and has focused largely on the evaluation of commercially produced materials. The results of such studies have consistently revealed that packages designed to individualize instruction have been effective in enhancing progress in certain academic areas across groups of children.

Positive reinforcement is recognized by teachers in exemplary programs as paramount to child growth. When teachers think and talk positively, they tend to act positively. On the other hand, when teachers think and talk negatively, they are prone to act negatively. Almost anything we say about a child can be said in positive terms. To say, "We need to help Johnny develop more adequate interpersonal skills." is positive and evokes positive action. On the other hand, to say, "Johnny can't get along with anyone. Everywhere he goes, he starts trouble." is negative and issues no call for action. Instead, such a comment suggests that Johnny's case is hopeless.

Positive reinforcement and feedback go hand in hand. We all like to know how we are doing. The more positive the feedback, the better the chances the child will put forth more effort. Teachers should monitor themselves from time to time to see how positive they are toward the children and parents with whom they work. This data will help them to determine if they need to acquire more positive behaviors. Some teachers even enlist the help of older, non-handicapped children to observe and record certain forms of teacher behavior. Oftentimes.

supervisors or administrators are willing to play such a data gathering role. Inservice training can also concentrate on this important aspect of teacher behavior.

The current philosophy of special educators is more positive than here-to-fore. Rather than concentrating on what a child can not do, we think of what he can do, of what he is capable of becoming and of what we can do to help him. We do not ignore his weaknesses, but we reinforce him for his efforts and successes, no matter how far he lags behind his peers.

Enhancing the child's self-concept is one of the most important concerns of teachers in exemplary programs. When we talk about promoting self-concept, we must again emphasize teacher behavior. Richardson (1965) emphasizes the important role teachers play in the development of the child's self-concept:

> The teacher is in control of several aspects of learning which have a direct impact upon each child's perceptions of himself as adequate and worthy or inadequate and unworthy. While the parent has influenced the child's self concept earlier, the teacher has a more powerful influence, especially in aspects of the self concept relating to intelligence and competencies. Consciously or unconsciously, the child thinks, "Who can know better than the teacher whether I am bright or dumb?" Early and careless estimates of children's abilities, while often erroneous, have a lasting effect. (p. 41)

Research as well as experience document that the following teacher behaviors nurture a positive self-concept among children. In additon, these behaviors help the teacher to determine the child's readiness to learn certain materials as well as his interests; to a considerable extent, then they ensure a measure of success.

- Adopting a calm, accepting, and supportive attitude rather than a threatening, punitive, and sarcastic attitude.
- Providing a well structured and reasonably demanding environmnet in which well defined expectations of the child are made.
- Creating opportunities for the child to make decisions.
- Establishing expectations where success is possible.
- Avoiding labels (mentally retarded, slow learner, hard-of hearing, emotionally disturbed).
- Relying on an immediate feedback system that allows children to know

how they are progressing.

Any behavior on the part of the teacher that makes the child feel rejected, unappreciated, and incapable of meeting expectations undermines the child's self-concept. The child then approaches tasks without the confidence he needs to succeed; almost invariably he fails. Failure further damages self-concept. In general, the more positive the teacher is, the more positive the self-concept of the child will be.

Concern over the affective development of children is another aspect of teacher behavior generally found in quality programs. Special educators, particularly, need to promote the interpersonal growth of their charges. We know that the handicapped fail most frequently on the job because of poor interpersonal skills rather than because they lack the cognitive and motor skills to do the job. The handicapped child needs help at an early age in perceiving how his behavior affects others. He also needs help in interpreting how the behaviors of others make him feel and in coping with certain behaviors of others. This area of development has been recognized as so important that experts in the field have developed materials that are now avialable commercially. These materials help teachers learn what they can do to create opportunities in the classroom to promote affective development. Simulated situations is one method that some teachers have found useful.

Professional growth is essential in exemplary programs, but it will not occur without teacher initiative. But administrative commitment must also be present and will be reflected in the budget.

Some methods for enhancing professional skills are attending workshops, reading professional journals and books, listening to experts share experiences and information, becoming involved in research, participating in case conferences, visiting other programs, attending and participating in conferences, viewing educational films or video tapes, taking courses, and professional writing. Information is generated at such a rapid rate that teachers must deliberately plan ways of keeping abreast of the latest knowledge and issues, and their supervisors must

encourage and reward these efforts.

Organizational Strategies

Both teachers and administrators in exemplary special education programs are concerned with the integration of the program within the total school system as well as with matters of internal organization. One of the broadest of these organizational strategies is mainstreaming; others of more limited scope include adult-child ratio, follow-up and transition procedures, and provisions for program evaluation.

Mainstreaming the handicapped child has become a very popular practice in the United States in recent years. Certainly, placement of the handicapped child in the least restrictive environment makes a great deal of sense. In addition, a federal mandate, effective September, 1978, will work toward the inclusion of handicapped children in the mainstream of public education. The intent of the law is to provide the handicapped child with equal opportunities for education.

The concept of mainstreaming handicapped children has implications for drastic change in such areas as school organization, curriculum, delivery systems, physical facilities, inservice training, and teacher education. When one concentrates on improving the educational program for one group of children, however, the quality of the educational program for all children almost invariably improves. Nevertheless, placing the handicapped child in the least restrictive environment is an easier concept to mandate than to implement. Regular teachers have not been trained to educate the handicapped, and special teachers in the past have not been trained to work as consultants to regular staff members. Such a team effort will require retraining that will hopefully be facilitated through carefully designed inservice training programs and university courses and workshops.

Routinely and automatically placing handicapped children in regular classes cannot succeed. In an exemplary program, each aspect of the child's development is carefully considered and goals and objectives for that child are delineated before he is mainstreamed. For one child, the plan may be to mainstream him only

for a 20-minute music period; for another child mainstreaming can be accomplished for the full day except for the time when he receives physical therapy and special equipment is needed.

Mainstreaming handicapped with non-handicapped children has been found to be beneficial to non-handicapped as well as handicapped children. Some of the adaptations and innovations for handicapped children are proving useful in promoting the growth of the non-handicapped; for example, individual educational plans and precise techniques of observation are strategies that will serve the non-handicapped as well as they have served the handicapped.

The most advantageous adult-child ratio is often difficult to determine, for it depends on the age of the child, the make-up of the class, the presence or absence of mainstreaming and the severity of the handicap. A good rule of thumb is that the ratio permit as much individualization of instruction as possible. Depending on the regulations and policies of a given locale, parents, volunteers and paid paraprofessionals can be used to extend the expertise of the professional staff and to meet the individual needs of children. Involvement of noncertified personnel, however, requires that the professional personnel have the skills to train the noncertified personnel and to organize and work with several adults in the classroom. Such an arrangement calls for highly competent professional staff.

There are definite advantages to teaching in small groups, even when teaching older children. If, for example, a class of 20 students 12 years of age can be subdivided into 3 or 4 groups, the adult in charge gets to know each child better and each child is able to participate more often than if the adult were to teach all 20 at one time. An adult teaching a small group can usually maintain eye contact with all pupils and thus keep their attention and interest to a greater degree.

In successful programs where the adult-child ratio is increased to meet individual needs of handicapped children, the roles of each adult are carefully delineated, but the head of the team remains the certified teacher. It must be

understood by other professionals, parents and the public that use of parents, volunteers, or even paid paraprofessionals in no way replaces the professional teachers. The added adults enable the professional to implement the individualized program that he/she has designed through persons who are capable of implementation but have not had the formal training necessary to design the program. Handicapped children often have complex problems which interfere with learning and require a great deal of individual attention to ensure progress, but school systems cannot afford to add professional staff to provide the required adult-child ratio. The alternative of using volunteers, parents, older children and paid paraprofessionals makes a desirable adult-child ratio feasible. Experience and research assure us that nonprofessionals can do direct teaching with children under the guidance of a strong professional.

Follow-up and transition procedures receive special attention in exemplary programs. This means that information of help to the receiving teacher is made available to that teacher. Thus, the current teacher must understand the program to which the child has been transferred and able to provide information to the receiving teacher that will enable him/her to write an appropriate individualized education program (I.E.P.) for the handicapped child with little or no waste of time. It is also desirable for the receiving teacher to visit the program in which the handicapped child has been enrolled. The more the receiving teacher is cognizant of the educational experiences and services the child has received, the better able he/she will be to help the child make a smooth transition from one program to another. When the current teacher and ancillary staff are aware of the placement options open to a handicapped child, the most valid decision can be made.

It is desirable for a case conference, usually held in the fall, to include the child's parents, the former teacher and ancillary personnel, and the staff presently responsible for the child's program. This staffing is usually scheduled after the receiving teacher has had an opportunity to study the cumulative records forwarded by the former staff and after the child has been in the

receiving program for several weeks. A mid-year staffing with the same personnel is usually desirable in order to determine how the child is progressing. Here again, parents can make valuable contributions to future planning. Another value in such staffings is to help former staff understand how their program can be improved to help the handicapped child make the best possible transition. In addition, former staff should be willing to serve as consultants to the receiving staff at times other than formal case conferences. Telephone conversations are often a useful procedure for sharing ideas, defining problems, and devising more appropriate programming.

Provision for ongoing evaluation is essential in achieving a quality program. Teachers are in a strategic position to determine how handicapped pupils are progressing through carefully kept anecdotal records, through samples of the child's work, through data which records how well specific objectives and goals have been met, and through standardized tests (achievement tests, sociometric tests, rating scales, questionnaires) as well as teacher-made tests.

Evaluations made by supervisors, administrators, and parents are also valuable in determining program strengths and weaknesses and in designing plans for improvement. Children can also sometimes be involved in program evaluation. The purpose of evaluation is, of course, to improve instruction, and in any exemplary program evaluation is an integral part of program development. To facilitate the handling of relevant data for evaluation, some schools have instigated a computer system whereby information can readily be recorded and retrieved.

Accountability is a key word in education today, especially in programs which include handicapped children. Providing individualized educational programs for handicapped children is expensive, and taxpayers as well as parents, want concrete evidence that the educational program for each handicapped child is really bringing about desirable growth and positive change. The Federal Public Law 94-142 mandates that each handicapped child be provided with a written, long-range educational plan and specific, day-by-day objectives to achieve those long-range goals. The law also requires that the professionals specify how they

will evaluate the child's progress in meeting those goals and objectives. To meet this stipulation, staff customarily use the comprehensive information they obtain on each handicapped child to predict on a timeline when that child will achieve specified goals and objectives in a given area. Subsequently, they determine what percentage of these objectives was met on schedule. Such evaluation is more thoughtful and more precise than former practices in special edcuation. Exemplary programs are not willing to assume that programs meet the needs of children without data to support such statements.

Parent Involvement

While educators have always recognized that parents are influential in the development of their children, they have tended to involve parents only minimally in the education of their children. There appear to be two major reasons why parents have not been involved to a greater extent. First, professionals often have a negative attitute toward parent involvement. Professionals generally argue that parents do not want to be involved and that if they do they are likely to be liabilities rather than assets to the program. It is not uncommon for professionals to label parents as "trouble makers." This attitude on the part of some professionals may be due more to a lack of skill in working with parents than to genuine feelings that parents have little to contribute. When one considers the training and experience of professionals, it is easy to understand why they hesitate to work with parents. They have had little formal training or preservice experience to make them competent in this area, and, unfortunately, inservice training is not usually directed to helping professionals become more skilled in working with parents.

Preschool programs have been far more open to parent involvement than programs for older children. Nevertheless, it is now recognized that the parents of any age child can assist the professional staff in formulating educational goals and objectives for their child. If the child is handicapped, United States Public Law 94-142 mandates parent involvement in developing an educational plan.

There are two attitudes that I consider extremely important in working with

parents. One is the understanding that parents must be treated as individuals. Involvement of parents in the education of their children must match entry-level participation with present needs and capabilities of an individual parent. For example, not all parents are ready to be involved in the direct teaching of children. The second attitude is closely akin to the first. Teachers who work with parents must be flexible. They must offer a number of alternatives from which parents can choose. In addition, school personnel, including administrators, must be flexible in arranging times for parents to become involved. It may, for example, be necessary to free teachers during the day to converse with parents. Practical suggestions for engaging parents in a number of meaningful activities are discussed in detail in Karnes and Zehrbach (1972). Basic assumptions professionals must have to ensure the success of parent involvement are discussed in another publication By Karnes and Zahrbach (1975).

There are many reasons why schools should involve parents. A major one is to launch a consistent plan for promoting the growth of the child at home and at school. When home and school work together, learning is reinforced and extended. There need be no regression during weekends and holidays if the family promotes the child's growth while he is at home.

Parents must rely on school personnel to provide them with the training and information that will enable them to be effective members of the child's educational team, especially if the child is handicapped. With guidance, most parents can become active participants in assessing their child's development and in developing appropriate educational plans. Parents also need encouragement in assessing their own needs, for only when the needs of parents are made known can the content of parent training be determined.

Summary

In essence, an examplary program does not overlook the value of each individual involved in the program--not only the child in the classroom but also the members of his/her family and the staff. This approach is refered to as the hu-

manistic approach because it is based on the recognition and appreciation of the dignity and rights of each individual.

In discussing the components of an exemplary program, I have relied heavily on my own experiences and on the opinions of experts. When there were research findings to reinforce my thinking, I felt especially secure in promoting a point of view; however, my major purpose in sharing my ideas with you has been to urge you to take a more critical look at your own program for handicapped children and to identify areas where you need to intensify your efforts or modify your program so that it will indeed have the ingredients to ensure a quality program for your handicapped charges.

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SECTIONAL PRESENTERS

CREATIVE USE OF A RESOURCE LIBRARY
For Meeting Teacher Competencies,
Serving Native American Pre-Schoolers

Susan Bailey — Tri-State Tribes

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Tri-State Tribes, OICD, offers technical and training assistance to Head Start programs on eleven reservations in Montana, Idaho, and Wyoming. The Indian Migrant Program Division of the Department of Health and Human Services funds the Office of Indian Child Services to provide technical and training assistance to the Head Start programs for the tri-state area. The technical and training assistance offered by the Office of Indian Child Services (OICS) includes but is not limited to (a) Personal Management (b) Child Development Associate training to classroom staff, (c) Accreditation of CDA participants, (d) Administrative assistance in all areas of program planning (grant and proposal writing, budgeting and review), (e) Staff and parent training in all component areas of Head Start Performance Standards, and (f) Handicap Services.

The Handicap services provided by OICS include these areas, but are in no way all inclusive, (a) T/TA to parents and staff, (b) direct services to children, (c) coordination with other agencies for the education of preschool children and (d) identifying and coordinating resources which are both human and/or material.

As funds for serving our programs were being curtailed, identifying and coordinating human and/or material resources became a top priority for Handicap Services to our programs. The Resource Library for the eleven Head Start grantees in our tri-state area was developed to satisfy the critical need for these often unavailable human and material resources. We saw our Resource Library to be particularly critical to our grantees due to their general geographical isolation and remoteness to metropolitan areas which bolster a prolifera-

tion of community resource agencies and/or recently formed Resource Access Projects.

The generic design of our Resource Library is to use materials that are made available to the eleven Head Start Coordinators, trainers, etc. on an on-going basis. The plan for implementing the Resource Library included the following, but was not limited to:

1. A general lack of education/special education resources and materials in the general community of the local grantee.
2. The size of a local Head Start grantee warrants a centrally located resource library in order to provide comprehensive serviced to satellite centers.
3. Provide relevant materials and special resources relevant and/or relative to the needs of Indian Children.
4. Local grantees did not have funds or space for the purchase, display, and replenishment of materials and resources.

When developing our lending Resource Library, several aspects needed to be considered so that the development was systematic and uniform for all involved. The following steps describe how we came about acquiring materials, funding, and dissemination.

First, we completed a needs assessment for the acquisition of materials from each of our programs. This was accomplished through a questionnaire and direct observation as we made on-site visits to our programs.

The next step was to initiate the ordering. This was accomplished by the needs assessment for requests, visiting other libraries to seek materials which would be most effective, mass mail-out for catalogues and free and inexpensive meterials, contacting state offices, political offices such as Senator Max Baucus, searching through educational magazines, as well as drawing from our own experiences and expertise. The next step was to pre-view materials. In view of our extreme geographic isolation, populations and needs, etc., all material needed to be previewed to ensure our specific criteria were met.

In establishing and developing the library, we did encounter some pitfalls. One of the problems was the acquisition of space and staff to assist with pre-

viewing and ordering. To allieviate the staff problem, we acquired an intern from Eastern Montana College. The intern assisted with the ordering, previewing, and actual development of the library system which led to the next concern -- determining a cataloguing system and categories. Because we work with Head Start Programs, we based the categories around the six components of Head Start. These categories; education, health/handicap, nutrition, parent involvement, social services, and administration became the basis for expanding into many specific sub-categories. We also divided the material into printed material and non-printed material, such as films, filmstrips, kits, realia, slides, etc. Finally, we needed to proceed with the printing and dissemination of a resource directory and establish rules and a check-out process.

The Resource Library and the C. D. A.

In developing a lending resource library, we also needed to ensure that the needs of the classroom teacher who is enrolled in the Child Development Associate program would be met as well as the needs of handicapped children.

A Child Develoment Associate (CDA) is a person who works with children, ages three to five, in a child-development center. The individual has been awarded the CDA credential after satisfactorily demonstrating competence in his or her performance with children. A CDA takes primary responsibility for a group of children in a center and is able to meet the specific needs of these children - by fostering their physycal, social, emotional and intellectual growth; by setting up and maintaining a healthy child - care environment and by establishing a good relationship between the children's parents and the child-development center. However, they may need to consult with a master teacher, other peer professionals, or appropriate specialist to insure a quality program for young children.

CDAs work in a variety of places and programs, e.g., nursery schools, parent/child cooperatives, day-care centers, Head Start programs. The one common thread being -- CDAs work with three- to five-year old children in centers.

An individual can become a CDA when he or she is able to (1) meet the CDA Consortium's eligibility requirements and (2) demonstrate the Consortium's standards of competence. To be eligible for candidacy for the credential, one must:

- Be at least 16 years old.
- Know of a center where he or she can be observed working with children.
- Have had at least eight consecutive months of full-time experience or 16 consecutive months of part-time (less than three days a week) experience working with three to five year old children in a group setting, and with their parents.
- Have had either some formal training (in a university, college, junior college or a high school) or some informal training (in workshops, seminars, or in-service programs) in early childhood education-child development.

A CDA must meet competency standards set by the CDA Consortium. At the heart of the Consortium's Competency Standards are these six "Competency Areas":

1. Establishiment and maintenance of a safe and healthy learning environment
2. Advancement of physical and intellectual competence
3. Support of a positive self-image and individual strength
4. Promotion of harmonious interrelation between children and adults in a group environment
5. Development of good coordination between home and center with regard to child-rearing practices and expectations
6. Ability to carry out supplementary responsibilites related to children's programs

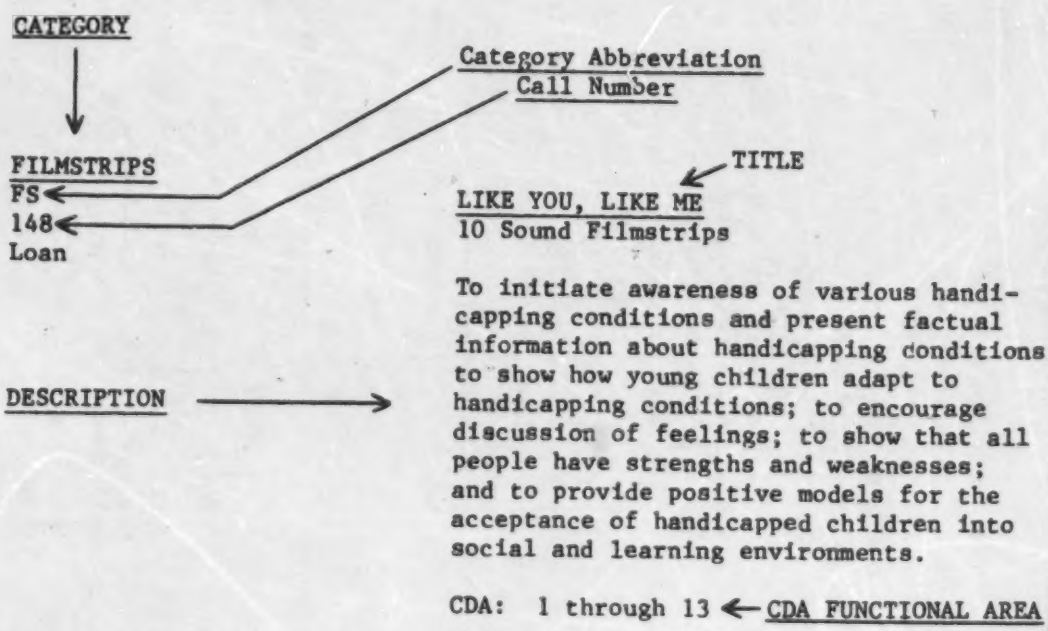
The CDA competencies are the substantive foundation for both training and accreditation of the Child Development Associates. For our Head Start programs, policy directives include handicapped children in regular programs. The competencies are applicable generally to persons who work with all young children, including situations where handicapped children are integrated into regular groups.

We designed a dual purpose system of cataloguing the resource library materials to assist the CDA candidates in meeting the accreditiation requirements in the competency areas and to facilitate maximum usage of the materials to meet

the needs of the handicapped child. Because each competency area of the CDA structure is listed with Functional Areas (key works), it was decided to catalogue according to the Functional Areas.

For example, if one is working on the competency area, The Third Functional area (Learning Environment), the CDA candidate selects materials and equipment and arranges the room to provide an environment conducive to learning and appropriate to the developmental level of the child. Given a situation where the teacher has a vision-impaired child, the teacher should have knowledge about working with children with impaired vision and provide a variety of materials that enable the child to have experiences with senses other than sight.

The CDA candidate can take the resource directory, turn to the section in each category to Handicapping Conditions, find materials that will fill the third functional area and also become knowledgeable about working with the handicapped child. An example of the cataloguing system and CDA Consortium Competency Structure follows:


CATEGORY
FILMSTRIPS
FS
148
Loan
Category Abbreviation
Call Number
TITLE
LIKE YOU, LIKE ME
10 Sound Filmstrips
DESCRIPTION
To initiate awareness of various handicapping conditions and present factual information about handicapping conditions; to show how young children adapt to handicapping conditions; to encourage discussion of feelings; to show that all people have strengths and weaknesses; and to provide positive models for the acceptance of handicapped children into social and learning environments.
CDA: 1 through 13
CDA FUNCTIONAL AREA

As the importance of education and development in the early years of a child's life gains greater recognition, new approaches should be developed to establish sound programs to meet those needs. The creative use of our lending resource library, hopefully, is such an approach.

## THE CHILD DEVELOPMENT ASSOCIATE CONSORTIUM

## COMPETENCY STRUCTURE

**DEFINITION OF THE CDA**

The Child Development Associate of CDA is a person able to meet the specific needs of a group of children in a child-development setting by nurturing children's physical, social, emotional and intellectual growth, by establishing and maintaining a proper child-care environment and by promoting good relations between parents and the child-development center.

**COMPETENCY AREA**

| I | II | III | IV | V | VI |
|---|---|---|---|---|---|
| Establishes and maintains a safe and healthy learning environment | Advances physical and intellectual competence | Builds positive self-concept and individual strength | Promotes positive functioning of children and adults in a group | Brings about optimal coordination of home and center child-rearing practices and expectations | Carries out supplementary responsibilities related to children's programs |

**FUNCTIONAL AREA (Key Words)**

| I | II | III | IV | V | VI |
|---|---|---|---|---|---|
| 1. Safe<br>2. Healthy<br>3. Environment | 4. Physical<br>5. Cognitive<br>6. Language<br>7. Creative | 8. Self-Concept<br>9. Individual Strength | 10. Social<br>11. Group Management | 12. Home<br>Center | 13. Staff |

# INTERDISCIPLINARY INSERVICE TRAINING FOR IDENTIFICATION/ASSESSMENT OF PRESCHOOL HANDICAPPED CHILDREN: A FUNCTIONAL PLANNING MODEL

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Over the past two years Count Your Kid In, the Kansas Child Find Project, has sponsored several interdisciplinary, interagency inservice trainings in the area of identification/assessment of the preschool handicapped child. A functional planning model has evolved from organizing these trainings. The model was developed from an administrative point of view and stresses organizational planning and implementation rather than presentation content. The content of this paper will include history, philosophy, and model procedures to organize and administer interdisciplinary trainings.

Interagency involvement has been a vital component of the Count Your Kid In Project from inception in 1976. The project has evolved from being responsible for the activities to locate unserved and underserved handicapped children statewide to our present responsibility of providing technical assistance and innovation to the local districts as they locate, identify, evaluate, and serve these children. A variety of agencies in addition to the local education agency have been involved in each step of the initial identification/screening process: helping to organize the screening; providing staff for the screening; and being a referral source and/or evaluation source. In an effort to improve the screening/identification process and state level input into this process, an evaluation form was developed for the screening staff which is utilized immediately following a local screening. This ongoing evaluation process has served as a needs assessment as the state project moved into a technical assistance role. Two areas were identified for state level technical assistance: 1) information and training on

coordination of a local screening, including media support; 2) training in the area of screening/identification/evaluation of young children.

It was relatively easy to provide the technical assistance required in number 1:

A comprehensive coordinators manual was written to cover all aspects of the screening model. The manual is broken into two coordinated parts, a narrative description of the model and sample forms for each step of the model process. This manual is used as the cornerstone for the screening coordinators training sessions. In order to further support local screening efforts, the Count Your Kid In Project provides office staff training, is available to answer questions by telephone, provides media releases and print materials, and will provide on-site assistance when needed.

Providing the technical assistance requested in number 2 was to be a more difficult task since each discipline would need specific information. Therefore we used problem solving strategy to develop our training: (see figure 1)

Awareness

Having worked in the area of screening/assessing young children for several years we had some idea of what kind of skills the personnel was bringing into a Count Your Kid In screening. Most were professionals in areas like: psychology, speech/language, physical therapy, occupational therapy, social work, and nursing; with little experience in working with young children. We were often told by the professionals or their screening coordinator that they were unfamiliar with test instruments and techniques to use with young children. Therefore, our general awareness of the problem was raised.

Information

The screening evaluation form mentioned earlier served as a needs

assessment and validated our awareness that there was a need for specific training for screening/identification/evaluation skills for persons who would be working with young children. The needs assessment was also our first step in gathering information. Next, we began investigating the availability of such training either through the universities or other agencies and found that none currently existed.

Definition

Through awareness and information gathering we had determined that there was a need for specific training for persons who would be working with young children and such training did not exist.

Goal

In order to determine exactly what skills, knowledge, and population to address with our trainings, we fell back on the expertise of our interagency/interdisciplinary contacts. A committee of representatives from the University of Kansas Children's Rehabilitation Unit, Kansas Department of Health and Environment, Kansas State Department of Education, and local education agencies was formed to provide input into the development of the training.

After being presented with the information collected, the committee made some different assumptions from those we expected. They felt there was a greater need to provide interdisciplinary/interagency information which would include specific information in several professional areas to an interdisciplinary/interagency population. Their focus was to present the value of early developmental screening; to discuss methods used in developmental assessments in order to encourage appropriate referral systems.

Alternatives

A variety of format designs were discussed by the committee. After taking into account the amount of information to be included and personnel issues like release time, the committee decided upon a one day format

presented in four locations. Professionals in the field of medicine, motor development, psychology, vision, hearing, and speech/language would be presented along with a component on local referral systems. It was also determined that an extensive syllabus with information from each area would be necessary for participants to gain maximum benefit from the training.

Decision

Armed with information from the committee we began to secure presenters for the workshop. We were requesting that the presenter's employing agencies release them for the presentation but Count Your Kid In would provide travel and expenses. Once all the presenters were secured, a meeting was set to discuss the workshop, the presentation content, and syllabus materials.

Planning

The presenter's meeting also provided an opportunity for input on issues like recruitment, credit options, and locations.

The Count Your Kid In staff then obtained continuing education credit for physicians, nurses, social workers, and physical therapists. Meeting rooms in the cities designated for the trainings were booked. A brochure was designed and mailed out to professionals in the areas of medicine, special education, physical therapy, occupational therapy, psychology, social work, speech/language, hearing, vision, and nursing. Mailing lists were obtained from the University of Kansas College of Health Sciences, Division of Health Care Outreach and Continuing Education; Kansas State Department of Education, Special Education Administration Section; and professional organizations. Fees to the participants were set which did not cover all the cost for the workshop, but did pay for the catered lunch and the syllabus.

Details like arranging the catered lunches, arranging for audio-

visual needs, and making reservations for the presenters were also handled by Count Your Kid In during the planning phase.

Evaluation

Evaluation for the trainings was obtained on two levels. First, we developed an evaluation form for participants to complete following the workshop. We also obtained informal evaluations from our presenters, either before or following a training. This way we were able to make almost immediate changes based on the formal evaluations, and we could more finely tune the content of our trainings.

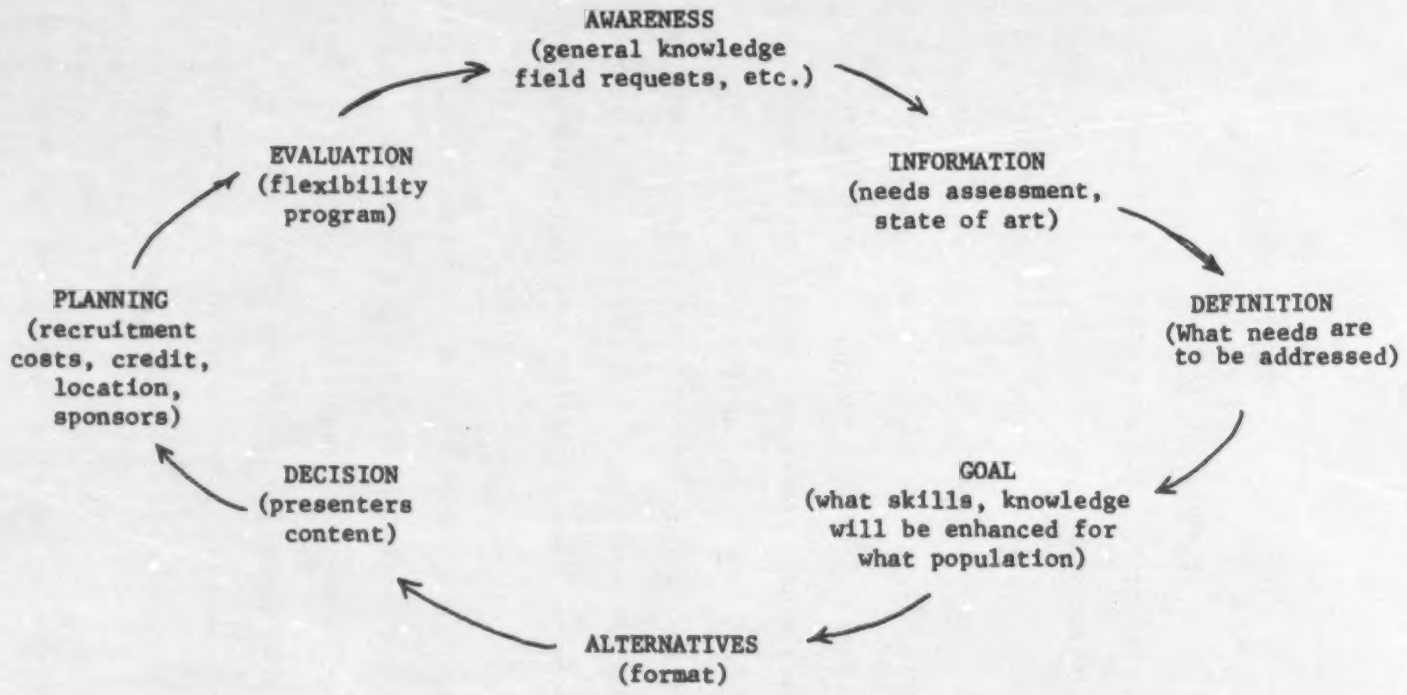
Overall the model worked very well. We were able to move from information gathering to the first training in five months. Naturally there were some unforeseen problems. In one location our meeting room had been booked for three separate groups at the same time and our caterer was late. We also had to try three different presenters in one professional area before we finally found someone who could present the kind of information required.

A unique aspect of our planning model has been the way we utilize our committee. Often things designed by a committee become very cumbersome, barely resemble the original intent, and are very slow to develop. In order to reduce the negative effects of design by committee, but still retain the benefit of a variety of perspectives we utilized our committee for input and final approval only.

In order for this to work our committee members (all professionals) had to be shown that we could be trusted in several areas: 1) To provide orderly meetings, with agendas distributed prior to the meeting. This way the meetings did not bog down or rehash the same issues. 2) To listen to their input and utilize it as we implemented the details. 3) To provide them with final approval (or disapproval) after we had organized the consensus decisions.

The benefits of providing this type of training are still being felt. The interagency/interdisciplinary contacts made during organizing this and other trainings have laid the groundwork for a number of new projects. We have been invited to be involved in trainings on the role of primary care physicians and the young handicapped child. We are working jointly with the Kansas Crippled Children's Program in developing secondary level regional evaluation clinics for children. We are also made aware of new programs as they develop; like motor development evaluation teams available statewide; so that we can pass the information on to local districts.

Though it initially takes extra effort to include a variety of agencies in the development of a workshop, we have found that the variety of benefits make the effort worthwhile.


AWARENESS
(general knowledge
field requests, etc.)
INFORMATION
(needs assessment,
state of art)
DEFINITION
(What needs are
to be addressed)
GOAL
(what skills, knowledge
will be enhanced for
what population)
ALTERNATIVES
(format)
DECISION
(presenters
content)
PLANNING
(recruitment
costs, credit,
location,
sponsors)
EVALUATION
(flexibility
program)

INDEPENDENCE V.S. AGENCY ADDICTION:

DOLLARS AND SENSE OF THE HOME TRAINING MODEL

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## Supportive Research

Longitudinal research regarding early intervention indicates that it is cost effective for society to provide such services to the young. Lazar and Darlington (1979) reported lasting effects of early intervention with disadvantaged preschool children. They found that early education for low income children programs, 1) significantly reduced the number of children assigned to early education, 2) significantly reduced the number of children retained in grade (grade failure), 3) significantly increased children's scores on fourth grade mathematics achievement tests with a suggestive trend toward increased scores on fourth grade reading tests, and 4) helped program children surpass controls on the Stanford-Binet IQ test for up to three years after preschool programs ended while Wechsler IQ scores show that children who attended preschool maintained higher scores for ten to fifteen years.

A review of the literature on early intervention with handicapped preschool children published by Lazar and Darlington (1979) indicates that 1) early intervention nas a major effect on the young handicapped child's life, 2) this effect tends to last through eighth grade, and 3) the curriculum used is not as important as the methodologies. The important variable necessary for the success of an early intervention program appears to be a highly organized set of curriculur instructions.

Although there is not yet conclusive evidence about what service delivery method produces the most effectivc early intervention program, the necessity of high degrees of parent involvement is widely recognized as one characteristic of exemplary early intervention programs.

Urie Bronfenbrenner (1974), who conducted an in-depth survey of a variety of early intervention programs concluded that:

> .....The evidence indicates that the family is the most effective and economical system for fostering and sustaining the development of the child. The evidence indicates further that the involvement of the child's family as an active participant is critical to the success of any intervention program. Without such family involvement, any effects of intervention, at least the cognitive sphere, appear to erode fairly rapidly once the program ends. In contrast, the involvement of the parents as partners in the enterprise provides an on-going system which can reinforce the effects of the program while it is in operation, and help to sustain them after the program ends (p.55).

Goodson and Hess (1975) found that programs with a home-based component (parent consultants or trainers working with parents in their own home)

> .....The home visit programs more consistently produced higher immediate gains and more often showed long term maintenance of gains . . .The home visits offer the possibility of a more intense teacher/parent relationship and a greater potential for personal rapport between the two (p. 24).

Other researchers have looked at what components made a home-based program successful. Dudzinski and Peters (1978) emphasized the need for a strong support system to help families meet basic needs for food, shelter and clothing which, if left unmet, would make the educational needs of the child seem relatively unimportant.

> .....A final factor in successful programs is the degree to which they provide a complete family support system. The need for such a system varies with the population being served . . .A more comprehensive support system may be necessary for more severely disadvantaged or disorganized families. This might include nutritional guidance, instruction in home management skills, and referral to other social service agencies, as well as some monetary relief to ease the burden of survival. (p.67)

J. H. Stevens (1976) concluded that the following four components characterized an effective home-based early intervention program:

1) The parent consultants (home visitors) were clearly specified.

2) The training objectives were clearly specified.

3) Activities were developed to meet the objectives.

4) Activities were implemented consistently and uniformly.

He concluded that a home visitor must "achieve a proper balance between prescriptiveness and personalization" (p.59).

Goodsons and Hess (1975) analyzed 20 early childhood programs and found that effective parent involvement was dependent upon:

1) the degree of planning and structure in the curriculum or the validity of the curriculum in the parent's eyes, and,

2) how well the content functioned to involve parents.

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## COST OF SERVICE DELIVERY OPTIONS

## CURRENTLY AVAILABLE IN MONTANA

A wide variety of costs currently exists among services available to Montana families who have a young handicapped child. A non-handicapped child has basic needs totalling about $4000 annually according to the United States Department of Agriculture (USDA) and Montana county and city government agencies. Regular education in Montana costs an average of about $1850. Average cost of special education nearly doubled the educational costs for a child during the 1980-81 school year (average $1600 per child). The average cost of providing respite care to a natural or foster family for Fiscal Year 1981 was slightly more than $400. If the family also participated in family training services during Fiscal 1981, the additional cost was $2400.

The child's placement must also be considered. When the child is living at home, the parents generally are responsible for the basic care costs. In the event the child is placed in foster care, those same costs, which average $16,900 for Fiscal Year 1981, must be born by the taxpayer. Basic care costs of placement in natural homes, foster homes or children's community homes, however, do not accurately reflect the medical expenses involved in meeting the needs of developmentally disabled children since accurate information regarding their medical expenses was unavailable. It is recognized that medical costs for the handicapped child generally will exceed the $179 average included by the U.S.D.A. for medical needs of basic child care allotted for the "average" child.

In spite of these limitations in data, the trend toward cost effectiveness in serving handicapped children in the community, as opposed to the institution, seems clear. The projected budget presented to the 1981 Montana legislature indicated that in Fiscal Year 1982, it will cost over $46,200 to serve an individual in Boulder River School and Hospital. These costs, however, do include complete

medical care. This institutional cost of $46,200 should be compared to the cost of services in a children's community home (group home), which was the most expensive community placement option considered, where the annual expense for Fiscal Year 1981 was about $20,350. In comparison, it appears that the cost of institutionalization is nearly double that of even the most restrictive community placement, a children's group home.

Taxpayers and legislators need to pay close attention to future trends in costs of placement for developmentally disabled children when allocating funding to programs statewide. In general, it would appear that family training, which helps to maintain developmentally disabled children in natural and foster homes, is a highly cost effective service and may deserve future expansion in Montana.

## FAMILY NEED INVENTORY

The cost effectiveness of a home training model and it's strength and success rely heavily on the flexibility of service areas that can be addressed by a home trainer.

The title, home trainer, implies that some skill acquisition or behavior training will be taking place. Of course, that is true but it is often necessary for the home trainer to deal with more primary needs of family members before effective skill or behavior programs can be initiated.

A person who experiences week-long absences from the home due to an alcohol addiction, one who is physically abused or one who hasn't enough income to provide food and adequate shelter for his/her family will have a hard time carrying out adequate home programs. Even if that parent is convinced of the need for intensive early intervention, self-preservation (and the implied needs) is a priority for many families with handicapped children. Consequently, these basic needs are generating parental behaviors not aimed toward intervention with their handicapped child.

It is surprising how many of the families on the current STEP active caseload are experiencing stress of one type or another that directly affects or in-

terferes with home training, e.g.:

- 57% of the families currently served have experienced child related stress to the degree that an alternate residential placement was or is being considered for their handicapped child.
- 40% are experiencing financial problems that influence their ability to provide the basics of food and shelter to their children.
- 38% of the parents of current clients are being treated or have been referred for treatment of emotional disturbances.
- 26% of our families are dealing with severe medical problems within the family.
- in 16% of our families, at least one parent is illiterate (or classified as developmentally disabled) - one or more parent suffers from alcohol or drug abuse or has been reported for suspected abuse or nelgect.
- 14% of the parents involved have limited time to spend with the child (due to working hours or family size).
- 7% of our families are ethnically diverse to the point that communication is hindered by a language/cultural barrier (i.e., STEP serves one Indian reservation and several Hutterite colonies).

HOME TRAINER - ROLE VARIETIES

Obviously, there are a variety of needs to be dealt with before parental energies can be directed toward child-centered activities. Over half of the families served are stressed to the point that they are considering another residence for their child.

And since the goal of C&FS home training program is to keep the family unit intact, many aspects in the home environment may need stabilization before child-centered activities are feasible. Although it is agency policy to redirect specific problems (i.e., welfare, public health, social security, Head Start, Big Brother & Sister program, school districts, mental health and private therapies),

many families don't qualify for other aid, refuse aid from another source or the referred agency may be overloaded and unable to offer the immediate service that is needed. In these cases, home trainers may offer some limited counseling but are most apt to attempt to restructure the home environment to a degree acceptable to all family members. Restructuring an environment to change a source of irritation is likely to bring more insight to the problem areas for the ones involved and initiate a behavior change in a problem area.

For example, a single parent had a history of abuse with her child. In this case, however, the mother did have some insight into her problem (she knew that she hit her son because he got up in the middle of the night and noisily made a mess of the house). In this instance, the home trainer restructured the environment by insisting that the mother keep the child up later in the evening and made that acceptable to the mother by providing a box of quiet time activities to occupy the boy. As the child became accustomed to later bedtime hours, he started awakening later and later until the waking and sleeping schedules of the mother and child coincided.

In another case, a battered wife who had broken up her nuclear family was provided with interim shelter and a food source by a home teacher. It isn't unusual for a home trainer to relieve a stress situation by arranging respite care and/or daycare situations for children.

If the stresses of the family are not child centered (involving financial, emotional, marital, medical, alcohol/drug abuse), the home trainer will immediately refer them to another agency (such as the agencies mentioned previously).

However, it is often true that even with specific interventions by other trained counselors or social workers, home trainers remain involved - to provide supportive assistance, de-escalate a crisis or provide a more casual liaison between the client and the other agency.

The fact that a home trainer visits clients at their home, with parental approval (or request) and has an orientation to child but not parental deficits, tends to make the home trainer a non-threatening go-between for parents and other

agencies.

One client visits the home trainer weekly in her office to talk about his latest medical diagnoses (he suffers from heart problems and cancer). Since he is concerned that his wife, who is in a delicate mental state, would not be able to handle any more family crisis, the family trainer provides this valuable support service.

In one case, the home trainer was forced to apply physical restraint to an emotionally out-of-control client and arrange police transportation to a receiving home. Additionally, in this particular instance, both parent and child had to be prepared by the home trainer for the child's return home - behavior expectancies and contingencies set up and appropriate reinforcers arranged.

Once the environment is stable enough for skill acquisition and/or behavior training to begin, the home trainer may have yet some other barriers to effective programming (illiteracy, cultural differences, limited time of parents).

Not only does a program need to be sound from an educational/behavorial point of view - it needs to be realistic and acceptable to the family. Parents, as well as children, need to be oriented for success in order to achieve success before frustration appears. A mother with two other children hasn't the time to chart 6 separate programs three times a day with consistency. Even if the child is in need of such intensive intervention, the needs of other family members must be considered.

A Hutterite family had been urged by several agencies to provide their profoundly handicapped daughter with some stimulation activities - radio, tapes, toys, etc. However, their culture forbade such items within the colony and the parents refused to purchase them. The home trainer finally defined these items to the family as medical needs and brought them to the family as prescribed devices. As long as a "professional" from outside brought the items to the colony as "prescriptive devices", the family allowed the child to utilize these items.

ACCOUNTABILITY

In an effort to secure data as specific and accurate as possible, home

trainers have spent much time adjusting data collection systems to varying abilities and time frames to meet specific parental needs. Six cycle charting is hardly appropriate in most home settings.

Among the more simple data collection systems is a symbolic entry on a calendar. One home trainer had a client record a X on the appropriate day of her calendar each time her child tantrumed and had her enter a T following the X if a time out procedure was used with the child.

For the same child (whose mother can't read), the home trainer devised a chart to track completion of daily hygiene tasks that consisted of pictures taken of the child performing each task followed by a space grid (a square for each day of the week) which the mother checked upon completion each day. The home trainer checked the grid weekly and reinforced the child appropriately for completion of tasks at that time.

Another parent with limited skills and motivation was not keeping data consistently or correctly. After trying several data sheets and charts, the home trainer finally had the mother report the data by phone daily. The phone calls, per se, were reinforcing since the mother's socialization opportunities were so limited and, consequently, the reporting became very consistent. In fact, the mother was so conscientious and enthusiastic regarding her responsibility that she often called to report several times daily.

Another method of easing parental responsibilities regarding accountability methods is to shift the responsibility to the child with a token economy point system program. Some commom examples of a token system include: receiving stickers, chips, stars, points, coins at the completion of each required task and spending the tokens for designated privileges. If the child's ability permits, a visual representation of task achievement entered by the child himself becomes very motivating.

When programs are finally written, their effects need to be measured. Home trainers need to know when to change, accelerate and decelerate programs. Parents and children also need the feedback as motivation.

# FOCUS ON TEAMING: TRAINING INTERDISCIPLINARY TEAMS FOR PRESCHOOL PROGRAMS

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In recent years the concept of a team approach has emerged as a needed and beneficial method for delivering quality services to young handicapped children. The team approach is frequently discussed as an exemplary or model aspect of programs for handicapped children. Merle B. Karnes lists these characteristics common to exemplary programs across the nation: legislative and financial support, administrative leadership, family involvement, pre-service and in-service training, teaming, individualized instruction, precise planning and total development of the whole child, (Karnes, 1977). In Wyoming, as in other significantly rural areas, the diverse needs of the handicapped population and the scarce resources available to meet those needs make a team approach an especially compelling method of service delivery for preschool programs.

During the 1980-81 school year, the Handicapped Preschool Education Program, Department of Speech Pathology/Audiology, University of Wyoming, began a new model of in-service training: the training of interdisciplinary or transdisciplinary educational teams. The team approaches described here are a synthesis of different types of approaches discussed in the literature and their application in the Wyoming preschool programs that participated in team training.

What is a team approach? A simple definition of a team approach is the joining together of several professionals in order to create a unified and coordinated effort toward the education and treatment of a handicapped child. The word "teaming" is used to emphasize the active nature of the process. Theoretically there are three major types of team approaches: the multi-disciplinary, the inter-disciplinary, and the trans-disciplinary. Multi-disciplinary literally means many disciplines. An example of such a team is often found in the public schools where each member of the team is responsible for assessment,

recommendations and conducting intervention programs according to his/her orientation and as prescribed by his/her training. The structure of an inter-disciplinary team is more horizontal. More coordination and decision-making occur among disciplines. Team members may assess the child together, formulate and sometimes implement teaching and therapy strategies together. Duplication of services and professional time can be decreased. The trans-disciplinary team is built upon the inter-disciplinary concept. One of the distinct characteristics of the trans-disciplinary team approach is the program or case manager. The case manager may be the team member who delivers most of the direct services or the person who is responsible for coordinating all direct services to a child and family.

The inter-disciplinary and trans-disciplinary approaches are the most applicable to handicapped infants and preschool children. In Wyoming, programs' teams sometimes function as inter-disciplinary and trans-disciplinary teams, depending upon the service delivery system. In center-based programs, the teams can be described as inter-disciplinary. In home-based programs or where services are delivered in a mainstream setting such as a Head Start or day care center, the team may function as trans-disciplinary. The program manager is the home teacher or parent in home-based programs. The regular teacher in the mainstream setting may be the program manager and receive consultation, training, and program planning assistance from the other members of the team.

What is the composition of the team? Team composition or team membership is based upon the needs of the individual child and family. So, team composition can be changing. However, in Wyoming programs, there is a core educational team with constant membership. Core educational team members are the special education teacher, the speech and language therapist, the occupational or physical therapist, the program administrator or representative, parents and classroom aides. Changing members may be the home-based teacher, regular classroom teacher, physician, other medical specialists, social worker, psychologist, audiologist or other persons whose knowledge of the child is important to

the educational program. Most programs have multiple teams; for example, an infant and preschool team or an infant, preschool and mainstream program team. Team membership may change only slightly from team to team. For instance, an infant team may consist of the core educational team with the addition of the infant teacher. There are also special teaming relationships or mini-teams. Mini-teams may consist of the occupational therapist, speech and language therapist and special educator or the classroom teacher and aide or the home-based teacher and parent.

What does the team do? The day to day functions of the team are usually unique to the program and setting. However, there seem to be three clusters of team functions: team development, program planning and program implementation. Team development functions are related to the internal processes of the team. They may include setting team goals, defining the roles of the team as a whole and team members as individuals, determining an organizational structure (e.g., times for team meetings, team leadership, recordkeeping procedures), team communication and teaching and learning from other team members. Program planning and program implementation functions are related to the team's work with children. The team is involved in the screening and intake of children. When community-wide screenings are conducted, the team plans, participates in the screening process, reviews screening results and arranges for follow-up, whether referral or further assessment of the child. One of the most important of the team's jobs is to conduct a team assessment of each child. Each team member might see the child for assessment in their areas of expertise, e.g., the speech therapist will conduct testing and observation of the child's speech and language development, the teacher may assess the cognitive skills of the child or the social worker may conduct an interview or home visit to evaluate the family's needs. The team may choose to conduct an "arena" assessment, where two or three team members work with the child or the others observe one person working with the child. Whatever assessment method is used, the team's next

task is to assemble the assessment information during a case conference or staffing. This provides an opportunity for all team members to give their views and recommendations. After the initial assessment information is gathered, the real "give and take" work of the team begins-joint program planning. The team makes decisions concerning the appropriate placement of the child, services to be received, goals for the child and instructional strategies. The team continues to meet regularly throughout the year to review the child's progress, to alter teaching methods, and receive the ongoing guidance of team members. Team members may also be involved in joint program implementation, such as, team teaching, or the therapist in the classroom.

Why is the team approach beneficial to children and programs? There are several factors which justify a team approach as an improved method for educating handicapped children in a rural setting. Handicapped children, particularly the multi- and severely handicapped, often present a complex and changing array of problems and needs. These children need the combined skills of numerous disciplines. If the best possible services are desired, then it is necessary to access and coordinate all of the expertise available. A team approach can reduce the fragmentation that sometimes results when there is less coordination of services. In some situations a child may see a doctor for the management of medical concerns, the teacher for classroom instruction, the speech and oocupational therapists for individual therapy sessions with limited contact among the professionals. There is likely to be duplication or overlap in the services or activities and at least some confusion on the part of the child and parents. The implementation of a team approach serves to lessen the "tearing apart of the child" and contribute to a well-integrated learning environment for the child. The cooperative planning that occurs in a teaming situation encourages well thought-out strategies that tend to educate the "total child." Consistency and precise planning of instructional activities can also improve the generalization of skills from one setting to another or from one trainer (teacher, therapist,

parent) to another. A team approach results in a cost-effective use of scarce professional time and expertise. In rural areas, programs must use staff resources to benefit the greatest number of children, In Wyoming it is not unusual to find one occupational therapist, for instance, serving a large geographic area and large numbers of children. Other benefits to programs are sometimes less tangible but none the less important. A team approach may provide a built-in staff development program. Team members are constantly learning from each other and adding to their reportoire of job skills. A team approach may also serve to lessen the frustrations of a demanding and poorly paid job. When decision-making, planning and the actual teaching or therapy are shared, greater job satisfaction can result. One team member has said, "I just feel like I'm doing a better job with children, I like working with the team. It has made me want to stay here." A team approach may also lessen the sense of professional isolation often felt in rural settings or programs which require large amounts of travel.

The team training model. In 1979, a statewide regional system of services for young handicapped children was instituted in Wyoming. There are now twelve service regions rather than separate, local preschool programs. One program in each geographic region contracts for State and federal dollars and is responsible for serving all handicapped children, ages 0-6 in the region. Preschool programs found that different service delivery systems were necessary in order to serve larger areas and more children. It became apparent that a team approach could help solve some of the problems created by the reorganization of the preschool programs. Team training also appeared to be an effective method of delivering in-service training. By focusing on increasing the skills of key personnel (team members), it was anticipated that training would have a ripple effect on the skills of other program personnel. The Handicapped Preschool Education Program model of team training consists of two major components: the team training workshop and follow-up activities. Preschool programs who are

interested in participating are asked to submit a brief application showing the education and experience of each team member, their job duties and the ways they are already functioning as a team. Individual needs assessments are completed by each member regarding their needs for training in their own discipline and for training in the implementation or improvement of a team approach in their programs. A minimum of administrator, special education teacher, speech and language therpist and occupational or physical therapist from each program are required to attend the team training workshop, a 3-5 day workshop conducted in the early fall before school begins. The team training workshop is conducted by a team of trainers representing these same disciplines. The primary goals of the workshop are to provide a conceptual framework of the team approach and to facilitate the beginning of team development. Instructional methods include lecture, discussion and small group activities with an emphasis on role definition and role-playing activities. Workshop sessions may include team approaches and the team development process, the consultant teaming model, working with teachers in existing programs, team communication, role definition, team development of the IEP and strategies for learning, considerations in building an educational team and small group instruction for specific disciplines. As a final workshop activity, an exit interview is held with individual teams during which a team action plan is formulated and immediate follow-up needs are designated. Follow-up activities are conducted throughout the school year. Activities may consist of on-site training, e.g., small workshops for staff and technical assistance or consultation, e.g., a consulting OT may assist the team OT with program recommendations for a specific child or a consultant may assist the team in scheduling time for team meetings or improving team communication techniques. In addition, statewide topical conferences and a reference and materials library are made available to all preschool programs in the state. A year-end evaluation of team training and team development is conducted. The evaluation is two-part: internal evaluation is done using a team self-assessment; external evaluation is conducted by project staff. Based on

this evaluation, teams may enter Phase II of training and receive reduced levels of follow-up during the second year, as needed to maintain the team. Teams who experience an unacceptable amount of staff turn-over or teams who could benefit from continued close follow-up re-enter Phase I and repeat the cycle of training. See Figure 1.

Summative evaluation information is not yet available for the Handicapped Preschool Education Program's first year of team training. However, with few exceptions, project staff and team members report a high degree of success in the implementation of a team approach in participating programs. One of the likely conclusions is that this type of training and the subsequent implementation of a team approach makes a substantial contribution to quality services for young handicapped children.

The Handicapped Preschool Education Program is funded through the U. S. Office of Education, Office of Special Education, Division of Personnel Preparation and the Wyoming State Department of Education.

TEAM TRAINING MODEL

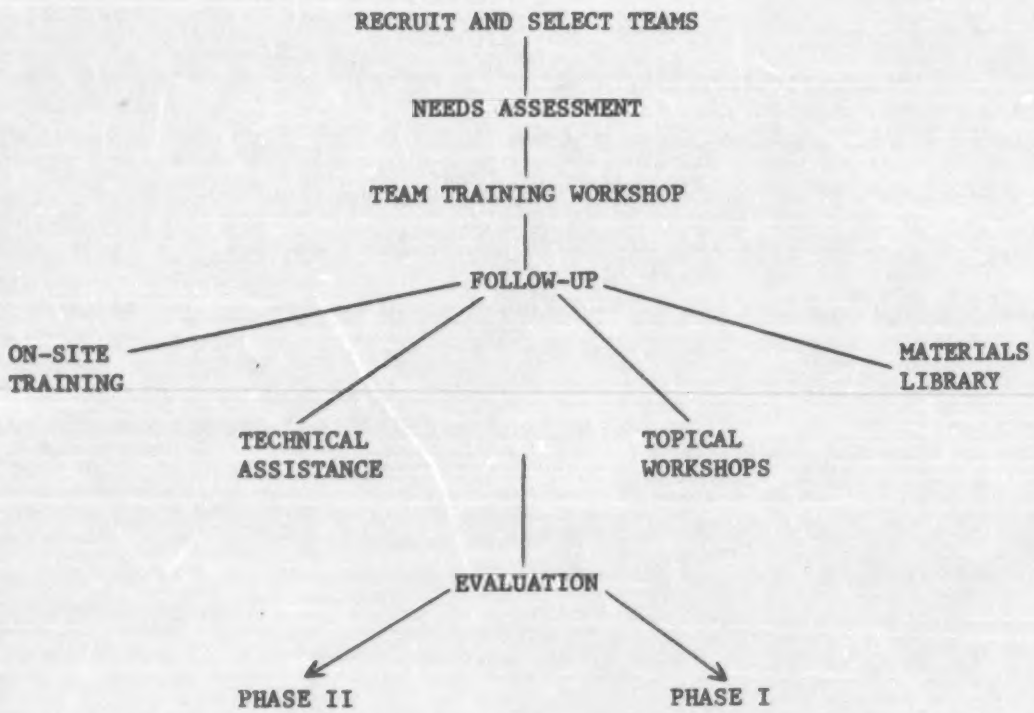


FIGURE 1

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BURNOUT:

SYMPTOMS AND SOLUTIONS FOR
TEACHERS AND PARENTS

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Various authors (Stevenson and Miit, 1975; Truch, 1980; Jones, 1968; Deschamp and Beck, 1979; Bensky, et. al., 1979; Helge, 1981; and Dixon, Shaw and Bensky, 1980) have discussed the issue of teacher burnout and factors that contribute this phenomenon. Burnout as described by Truch indicate:

> The symptoms include being tired all of the time, sleeplessness, depression, and being physically run down. Teachers experiencing burnout often have minor physical maladies such as frequent colds, headaches, dizziness, or diarrhea. If unchecked, these ailments may turn into ulcers, colitis or asthma or they may cause loss of appetite and loss of sexual interest.
>
> Teachers who feel physically unwell soon find themselves depressed by their symptoms. It's difficult to play kickball with the kids when you are tired and slightly dizzy. It's difficult to be excited about a topic you are teaching when you are uncomfortable and out of sorts all the time. Teachers report that their self-concept drops to a new low as they question the meaning of teaching. What's it all for, they ask. Why am I doing this? They see themselves becoming less effective with children and colleagues. "I have nothing to offer anymore," one teacher explained, "I hate coming to work. I am intolerant of childish behavior and I feel guilty collecting my salary. I feel as if I am a robot."
>
> First things hurt in body and mind; then they actually start to fall apart at school. The teacher feels guilty, incompetent as an educator and finally inadequate as a person. This of course, affects personal relationships. If unchecked, burnout can result in total emotional breakdown.

The initial questions to be asked by each teacher is: Why am I a teacher? What do I expect from the education system? Is teaching my career? Given this information the stage is set to predict in some cases who will make education a career and who will burn out. Statistics show that fifty percent of the teachers drop out before 10 years of service. This may be due to

other career choices or because of "burnout". Secondly, it has been found that people who enter education do so because they want to teach children, and don't drop out or burnout because they didn't like teaching. It is the combination of a set of factors that causes the teacher to burnout.

With the passage of public Law 94-142, stress has appeared to become more prevalent. The change in the definition of a teacher's responsibility has caused stress, and in turn, in cases less job satisfaction. The change of responsibilities to include more involvement with interdisciplinary staff meetings, due process hearings, monitoring child process, individualized education programs has created a burdensome environment for teachers to work in. Even though these provisions were developed to insure a free appropriate public education for all handicapped children, teachers, and school personnel are expected to comply with all regulations and at the same time develop the minds and bodies of each child.

In a study conducted by Bensky, et al. (1980) three major categories were evaluated in relationship to stress and P.L. 94-142. First, special education classroom teachers were found to be under less stress than resource room and regular classroom teachers. The authors point to the difference may be due to special education teachers in Connecticut have not changed due to P.L. 94-142, and the resource room and regular classroom teachers roles have been significantly changed. Secondly, teacher expectations as it relates to his/her own role and the expectations others have on that role. It is essential then to set a clear role expectation that correlates with the teacher's expectation. Another variable centered on compliance and P.L. 94-142. As teachers perceived the school district to increase its compliance with the regulations, teacher stress increased due to the specific requirements affecting the teacher, i.e. IEP's and due process. And finally, for all types of teachers, diagnosis and assessment was considered a highly stressful situation.

The working conditions for teachers has also contributed to poor teacher retention. In a rural setting the following description was made of the school: The school's science room was equipped with a world globe next to a hand-cranked electric generator. And a pickled frog in a Mason jar. The school library was a six-by-six room containing approximately 1,000 volumes. All were more than five years old. Extracurricular activities consisted of the 4-H Club, graduation ceremonies, basketball and baseball. This may be an extreme example, however, two-thirds of the nation's 16,000 public school districts are classified as either rural, remote or isolated because of sparse population or geographic location including mountains, deserts, or islands. More than 15 million children 5-17 are enrolled in rural schools (districts of 2,000 students or less) (Helge, 1979).

Helge (1980) also noted that many rural public school districts were compelled to hire young and inexperienced staff in special education. The isolation of social and cultural opportunity were significant factors that contributed to staff leaving to more urban centers. Attrition rates from 30-50% per year have been common and causes serious problems for program planning. Also, extreme weather conditions, inadequate housing and low salaries create conditions that cause difficulty in employing and retaining staff, and in some cases, remain unfilled.

Salary has been said to cause teachers to drop out of education; however, money is found only to be a factor for entry level teachers and not necessarily a factor over time. Given the economic conditions, cutbacks on educational programs, less increases in salary coupled with other variables can be found to cause stress, anxiety, and burnout. Also, teachers feel a responsibility to be creative and develop programs for children, such as field trips, teaching severely handicapped children to independently cross the street, shop in stores, and be educated in the normal environment, but becomes hindered by the lack of understanding by the school district when trying to

accomplish these tasks. Burnout results when the teacher feels she cannot do the job she was hired to do.

Another factor that is generally discussed is teacher work load. A new teacher is given an equal work load, number of children, etc. as a teacher who has been working for three to five years. Even though the University System graduates each student to be a competent teacher, the real world of work can be significantly different. A new teacher needs to develop materials, review programs, and organize lessons; however, the teacher may not have been taught to effectively organize and develop a learning environment for the children he/she was hired to teach. Secondly, the time and energy needed to accomplish this is enormous.

University training programs don't like to admit the training program may not provide appropriate knowledge skills and expectations for new teachers, but the fact remains, they sometimes don't. The school district; however, expects a competent teacher to be as good as or better than all other teachers in a particular situation. Multiply this situation with the fact that teachers of the handicapped are usually isolated with children all day, changing diapers, feeding, etc. and have very little adult contact from day to day. Teachers are usually isolated in their classrooms to develop plans for children, curriculum strategies, and long term planning with little contact or assistance from other staff and teachers who are doing the same thing. If a teacher has a free period, it may be taken up by lunch or playground duty and if not, there is very little time for constructive professional interactions.

For personnel working in rural areas, Glen Castro from Utah State University has found that recruiting personnel with qualifications and interests and attitudes consistent with the rural lifestyles lessen the likelihood of personnel being dissatisfied and unsuccessful in their position. He has identified seven areas that are critical in determining an employee's strength and needs:

1. acceptance of rural culture
2. rural interests
3. socially appropriate behaviors
4. personnel satisfaction with rural activities
5. knowledge of local history, geography and politics
6. ability to adapt to new, strange, and different conditions
7. local and long distance support systems

Castro has also indicated by using these seven variables, candidates can be identified who will never be successful in a particular teaching environment. Secondly, the assessment can also identify those individuals who are "at risk", where additional support measures will need to be developed. Seeing the need to train teachers to work in various rural situations, Western Montana College and others are now developing programs to train individuals to work specifically in rural schools.

How does a teacher prevent burnout, or assess the situation in order to determine his/her condition? Included in Appendix A are four profiles that can be used to determine stress levels. These shouldn't be used as an absolute evaluation or diagnosis but as a guide in determining the level of stress in your life. These four profiles have been extracted from: Teacher Burnout and What To Do About It by Stephen Truch, Ph. D.

Parents and "burnout" have also drawn attention as this society provides parents with the notion that children must be entertained and involved every minute of the day. Dr. Kiefaber points out stress comes from having to continue to meet the needs of people requesting help, a process which seems endless. And the person who has to provide the help feels drained, that there is no more to give. With the handicapped especially, there is a continual need to provide help and assistance often from birth to death. As one parent indicated about her son, "I am tired of teaching him at home, tired of fund raising, tired of the total support he needs every time I turn around."

The opportunity for a child in the 80's is tremendous with Little League, bowling, tumbling, Girl Scouts, Boy Scouts, etc. However, often both parents work and yet feel they must indulge their children in all activities if they are to be "good parents", when they cannot they feel guilty and that they are failing as parents. In recent research conducted on burned out parents, several common feelings surfaced:

1. that they are not able to be good parents.
2. that children are demanding more than the parents can give.
3. that they dislike their children, they are bothersome.
4. guilt, which leads to defensiveness which in turn leads to a variety of other problems.
5. physical exhaustion.

Five stages of burnout have been identified that are generalizable to parents and teachers alike. These five stages are:

1. the psychological level when people begin to feel tired, drained, and may develop physical ailments.
2. the social level when people become irritable, difficult to deal with. At this point individuals may begin to avoid people, not wanting social interaction.
3. the intellectual level when the burnout starts to affect the mind, the person is tired of thinking, sometimes, it begins to show up in difficulty of concentration.
4. the psycho-emotional level where the person begins to perceive himself/herself as always meeting someone else's need. Another symptom is a strong desire to be alone.
5. The introspective level where the person begins to question his own value system. He or she becomes less willing to contribute to others.

A solution that has been discussed centers around setting specific priorities for one's self and each child. A plan needs to be developed by the parent and teacher that allows enough time and energy to carry out the established goals. Secondly, an "energy audit" needs to be conducted by the parent and teacher as each individual has only so much energy.

There are various solutions to combat stress and burnout in teachers.

In the following section several will be described as viable alternatives to leaving the field of education.

Stress management as defined by Truch (1980) is called the R.E.A.D. Program. This stands for:

R - deep relaxation

1. progressive relaxation
2. diaphragmatic breathing
3. biofeedback
4. transcendental meditation
5. autogenic training
6. visualization

E - regular exercise

A - attitude and awareness

D - diet

The four ingredients become a framework for eliminating or at least coping with the world in which we work.

Patricia Weiskopf (1980) takes prevention from the personnel level of classroom teachers, and suggests the following ways to prevent burnout.

1. Special educators need to know in advance the type of emotional stress their particular job entails. Knowing the individual children and their degree of handicap assists a teacher in planning a program that will prevent excessive stress.

2. Teachers need to set realistic goals for themselves and their students. Planning for certain success on the job is necessary.

3. Special educators need to delegate responsibility for such tasks as paperwork and nonteaching duties to teacher aides or parent volunteers in order to relieve some pressure and reduce the work load. This relates to setting goals according to their value in the teaching-learning process.

4. Special educators should avoid isolation from other staff. Support from others is crucial to preventing burnout.

5. While on the job, teachers need to break up the amount of continuous, direct contact they have with children. Team teaching, use of learning centers, and teacher time outs can be implemented to reduce direct contact time.

6. Staying mentally alert when away from the job is significant to preventing burnout. Teachers may attend classes, workshops, or field trips to continue intellectual activity and to maintain contact with other educators. Sharing experiences and feelings through group participation activities can help teachers to relax and decelerate the process of burnout (Freudenberger, 1977).

7. Physical exercise is recommended to relieve stress and tension that has built up during the day. Many schools already have excellent facilities available for teachers to use.

8. To alleviate boredom, teachers need to be more creative on the job. Repetition and routines are inherent in both regular and special education; however, newness and variety create excitement and interest for all educators and their students.

9. Teachers may participate in active or passive hobbies and special interests not relating to the job. Developing expertise in another area enhances self esteem and self confidence, consequently rejuvenating the tired teacher (Landsmann, 1979).

Burnout eventually affects not only the teacher but the child, family and administration. To combat the problem, takes dedication of all involved. A teacher and school must establish priorities, select and retain teachers appropriate for the environment, help parents to understand their roles and limitations, and provide a clear picture describing roles and responsibilities, With these solutions and changes, perhaps there would be greater benefits to the children and less parent and teacher burnout.

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# APPENDIX A

Name_____ Date_____

School_____ District_____

## Stress Profile for Teachers

### Instructions

The Wilson Stress Profile for Teachers is designed to help you more clearly define, on a self-scoring basis, the areas and frequency of your stress. As you read each item, evaluate the statement in terms of a period of time rather than a specific day you remember. Indicate how often the source of stress occurs by circling the number that corresponds to the frequency of occurrence. Do not read the stress profile scoring sheet until after you have completed items 1-36.

| Student Behavior | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| 1. I have difficulty controlling my class . . . . . | 1 | 2 | 3 | 4 | 5 |
| 2. I become impatient/angry when my students do not do what I ask them to do . . . . . | 1 | 2 | 3 | 4 | 5 |
| 3. Lack of student motivation to learn affects the progress of my students negatively . . . . . | 1 | 2 | 3 | 4 | 5 |
| 4. My students make my job stressful . . . . . | 1 | 2 | 3 | 4 | 5 |

Total Items 1-4 _____

### Employee/Adminstrator Relations

| | | | | | |
|---|---|---|---|---|---|
| 5. I have difficulty in my working relationship with my administrator(s) . . . . . | 1 | 2 | 3 | 4 | 5 |
| 6. My administrator makes demands of me that I cannot meet . . . . . | 1 | 2 | 3 | 4 | 5 |
| 7. I feel I cannot be myself when I am interacting with my administrator . . . . . | 1 | 2 | 3 | 4 | 5 |
| 8. I feel my administrator does not approve of the job I do . . . . . | 1 | 2 | 3 | 4 | 5 |

Total Items 5-8 _____

### Teacher/Teacher Relations

| | | | | | |
|---|---|---|---|---|---|
| 9. I feel isolated in my job (and its problems) . . . . . | 1 | 2 | 3 | 4 | 5 |
| 10. I feel my fellow teachers think I am not doing a good job . . . . . | 1 | 2 | 3 | 4 | 5 |

| | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| 11. Disagreements with my fellow teachers are a problem for me | 1 | 2 | 3 | 4 | 5 |
| 12. I get too little support from the teachers with whom I work | 1 | 2 | 3 | 4 | 5 |

Total Items 9-12 _____

Parent/Teacher Relations

| | | | | | |
|---|---|---|---|---|---|
| 13. Parents of my students are a source of concern for me | 1 | 2 | 3 | 4 | 5 |
| 14. Parent's disinterest in their child's performance at school concerns me | 1 | 2 | 3 | 4 | 5 |
| 15. I feel my students' parents think I am not doing a satisfactory job of teaching their children | 1 | 2 | 3 | 4 | 5 |
| 16. The home environment of my students concerns me | 1 | 2 | 3 | 4 | 5 |

Total Items 13-16 _____

Time Management

| | | | | | |
|---|---|---|---|---|---|
| 17. I have too much to do and not enough time to do it | 1 | 2 | 3 | 4 | 5 |
| 18. I have to take work home to complete it | 1 | 2 | 3 | 4 | 5 |
| 19. I am unable to keep up with correcting papers and other school work | 1 | 2 | 3 | 4 | 5 |
| 20. I have difficulty organizing my time in order to complete tasks | 1 | 2 | 3 | 4 | 5 |

Total Items 17-20 _____

Intrapersonal Conflicts

| | | | | | |
|---|---|---|---|---|---|
| 21. I put self-imposed demands on myself to meet scheduled deadlines | 1 | 2 | 3 | 4 | 5 |
| 22. I think badly of myself for not meeting the demands of my job | 1 | 2 | 3 | 4 | 5 |
| 23. I am unable to express my stress to those who place demands on me | 1 | 2 | 3 | 4 | 5 |
| 24. Teaching is stressful for me. | 1 | 2 | 3 | 4 | 5 |

Total Items 21-24 _____

| Physical Symptoms of Stress | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| 25. The frequency I experience one or more of these symptoms is: stomachaches, backaches, elevated blood pressure, stiff necks and shoulders . . . . . | 1 | 2 | 3 | 4 | 5 |
| 26. I find my job tires me out . . . . . | 1 | 2 | 3 | 4 | 5 |
| 27. I am tense by the end of the day . . . . . | 1 | 2 | 3 | 4 | 5 |
| 28. I experience headaches . . . . . | 1 | 2 | 3 | 4 | 5 |

Total Items 25-28 _____

| Psychological/Emotional Symptoms of Stress | | | | | |
|---|---|---|---|---|---|
| 29. I find myself complaining to others . . . . . | 1 | 2 | 3 | 4 | 5 |
| 30. I am frustrated and/or feel angry . . . . . | 1 | 2 | 3 | 4 | 5 |
| 31. I worry about my job . . . . . | 1 | 2 | 3 | 4 | 5 |
| 32. I feel depressed about my job . . . . . | 1 | 2 | 3 | 4 | 5 |

Total Items 29-32 _____

| Stress Management Techniques | | | | | |
|---|---|---|---|---|---|
| 33. I am unable to use an effective method to manage my stress (such as exercise, relaxation techniques, etc. . . . . | 1 | 2 | 3 | 4 | 5 |
| 34. Stress management techniques would be useful in helping me cope with the demands of my job . . . . . | 1 | 2 | 3 | 4 | 5 |
| 35. I am now using one or more of the following to relieve my stress: | | | | | |
| alcohol, drugs, yelling, blaming, withdrawing, eating | 1 | 2 | 3 | 4 | 5 |
| 36. I feel powerless to solve my difficulties . . . . . | 1 | 2 | 3 | 4 | 5 |

Total Items 33-36 _____

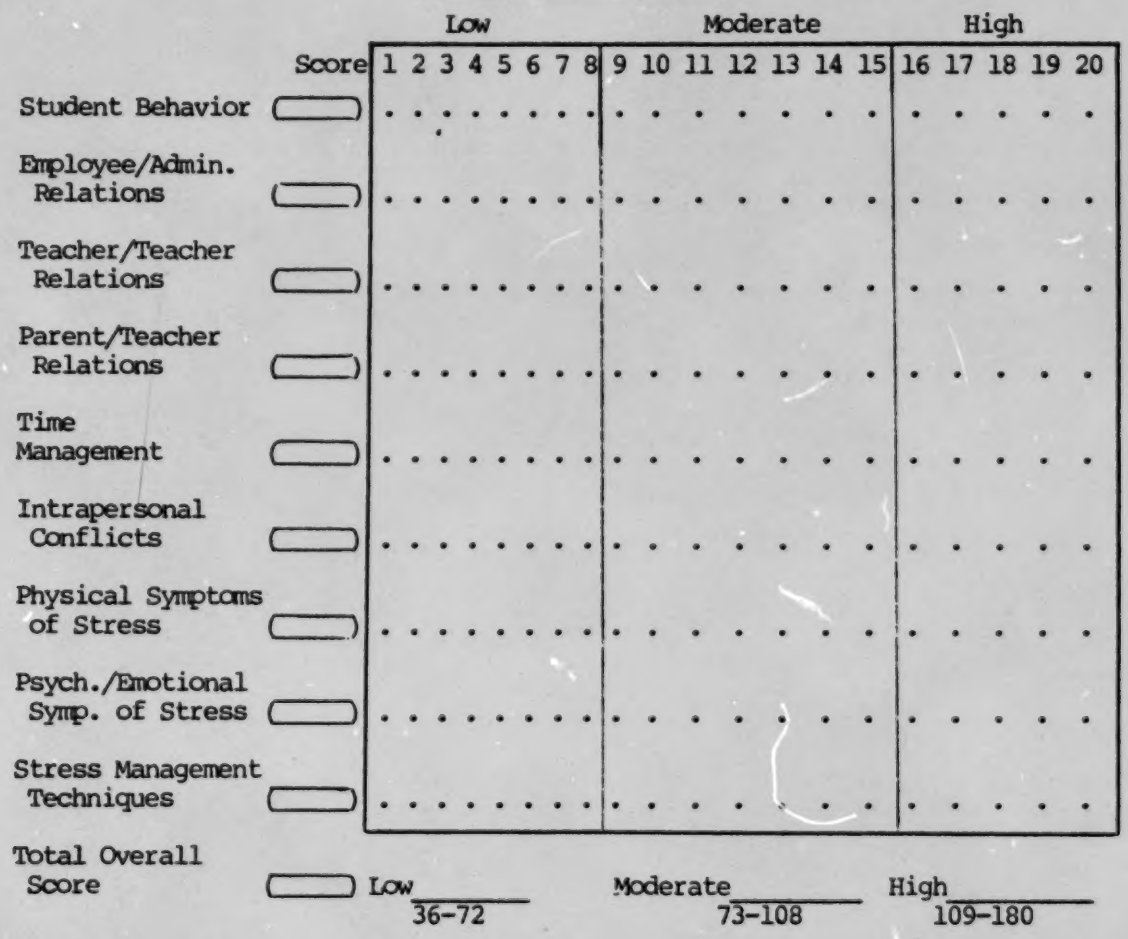
## Scoring Sheet

## Stress Profile for Teachers

### Instructions for Scoring

1. After you have completed items 1-36, total the scores in each category and enter it in the corresponding box on this page.
2. Plot your score on the dotted line with an "X" and draw a line between your scoring "X's" so that a clear profile of your stress evaluation is visible.
3. Add up all your category scores and enter the number in the box after Total Overall Score. A score of 36-72 is low, 73-108 is moderate, and 109-180 is high.
4. Check your level on the same line as either low, moderate, or high.

### Stress Profile Scores



"Hurry Sickness" Index

Please indicate how often each of the following applies to you in daily life.

| | Never | Seldom | Sometimes | Usually | Always |
|---|---|---|---|---|---|
| 1. Do you find yourself rushing your speech? | 1 | 2 | 3 | 4 | 5 |
| 2. Do you hurry other people's speech by interrupting them with "umhm, umhm" or by completing their sentences for them? | 1 | 2 | 3 | 4 | 5 |
| 3. Do you hate to wait in line? | 1 | 2 | 3 | 4 | 5 |
| 4. Do you seem to be short of time to get everything done? | 1 | 2 | 3 | 4 | 5 |
| 5. Do you detest wasting time? | 1 | 2 | 3 | 4 | 5 |
| 6. Do you eat too fast? | 1 | 2 | 3 | 4 | 5 |
| 7. Do you drive over the speed limit? | 1 | 2 | 3 | 4 | 5 |
| 8. Do you try to do more than one thing at a time? | 1 | 2 | 3 | 4 | 5 |
| 9. Do you become impatient if others do something too slowly? | 1 | 2 | 3 | 4 | 5 |
| 10. Do you seem to have little time to relax and enjoy the time of day? | 1 | 2 | 3 | 4 | 5 |
| 11. Do you find yourself overcommitted? | 1 | 2 | 3 | 4 | 5 |
| 12. Do you jiggle your knees or tap your fingers? | 1 | 2 | 3 | 4 | 5 |
| 13. Do you think about other things during conversations? | 1 | 2 | 3 | 4 | 5 |
| 14. Do you walk fast? | 1 | 2 | 3 | 4 | 5 |
| 15. Do you hate dawdling after a meal? | 1 | 2 | 3 | 4 | 5 |
| 16. Do you become irritable after a meal? | 1 | 2 | 3 | 4 | 5 |
| 17. Do you detest losing in sports or games? | 1 | 2 | 3 | 4 | 5 |
| 18. Do you find yourself with clenched fists or tight neck or jaw muscles? | 1 | 2 | 3 | 4 | 5 |
| 19. Does your concentration sometimes wander while you think about what's coming up later? | 1 | 2 | 3 | 4 | 5 |
| 20. Are you a competitive person? | 1 | 2 | 3 | 4 | 5 |

Rule-of-Thumb Interpretation

| | |
|---|---|
| 20-60 | O.K. (Possibly you're Type B) |
| 61-79 | Needs Improving |
| 80+ | Time Bomb! |

## Coping Scale

A number of ways people react to stress and tension are given below. Please indicate your own rating on each item by circling one of the five numbers at the right of each item. Please do not skip any items. You may take as much time as necessary. There are no right or wrong answers.

| When I am feeling stress and tension: | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| 1. I use alcoholic beverages | 1 | 2 | 3 | 4 | 5 |
| 2. I talk it out with others(friend, relative, or professional | 1 | 2 | 3 | 4 | 5 |
| 3. I try to find out more about the situation | 1 | 2 | 3 | 4 | 5 |
| 4. I daydream | 1 | 2 | 3 | 4 | 5 |
| 5. I believe in a supernatural power who care about me. | 1 | 2 | 3 | 4 | 5 |
| 6. I work it off by physical exercise | 1 | 2 | 3 | 4 | 5 |
| 7. I try to see the humorous aspects of the situation | 1 | 2 | 3 | 4 | 5 |
| 8. I don't worry about it. Everything will probably work out fine | 1 | 2 | 3 | 4 | 5 |
| 9. I sleep more | 1 | 2 | 3 | 4 | 5 |
| 10. I take some definite action on the basis of my present understanding | 1 | 2 | 3 | 4 | 5 |
| 11. I draw on my past experiences | 1 | 2 | 3 | 4 | 5 |
| 12. I use food and food substitutes (smoking, chewing gum, eating more) | 1 | 2 | 3 | 4 | 5 |
| 13. I get prepared to expect the worst | 1 | 2 | 3 | 4 | 5 |
| 14. I curse | 1 | 2 | 3 | 4 | 5 |
| 15. I make several alternate plans for handling the situation | 1 | 2 | 3 | 4 | 5 |
| 16. I use drugs | 1 | 2 | 3 | 4 | 5 |
| 17. I become involved in other activities to keep my mind off the problem | 1 | 2 | 3 | 4 | 5 |
| 18. I cry | 1 | 2 | 3 | 4 | 5 |

Interpretation:

In general, the more long-term coping mechanisms you employ, the better, although sometimes a short-term mechanism is very useful and occasionally a long-term one is not useful. The items and their classification are:

1. (Short-term)
2. (Long-term)
3. (Long-term)
4. (Short-term)
5. (Long-term)
6. (Long-term)
7. (Short-term)
8. (Short-term)
9. (Short-term)
10. (Long-term)
11. (Long-term)
12. (Short-term)
13. (Short-term)
14. (Short-term)
15. (Long-term)
16. (Short-term)
17. (Short-term)
18. (Short-term)

## The "Wellness Behavior" Test

This quiz will help you assess the behavior patterns that establish your own wellness. Use your judgment to give yourself a grade — A, B, C, D, or F, according to the following questions.

### Relaxation:

| | | |
|---|---|---|
| 1. Do you take time to get completely away from work and other pressures, to unwind? | Frequently | A |
| | Fairly Often | B |
| | Sometimes | C |
| | Seldom | D |
| | I "just can't" | F |
| 2. Do you sleep well? Fall asleep easily? Sleep through the night? | Very well | A |
| | Fairly well | B |
| | Not so well | C |
| | Have trouble | D |
| | "Certified Insomniac" | F |
| 3. Do you take, or feel you need, aspirin, tranquilizers, sleeping pills, stomach medicines, or laxatives? | Seldom or never | A |
| | Occasionally | B |
| | Fairly often | C |
| | Quite often | D |
| | I'm hooked | |
| 4. Do you practice a form of deep relaxation (e.g., meditation, progressive relaxation, autogenic training, etc.) daily? | Nearly every day | A |
| | Often | B |
| | Occasionally | C |
| | Seldom | D |
| | What's deep relaxation? | F |

### Exercise:

| | | |
|---|---|---|
| 1. Can you run a mile (at any speed) without becoming exhausted? | Easily | A |
| | Fairly well | B |
| | Can barely make it | C |
| | Can't do it at all | D |
| | Can't walk a mile | F |
| 2. Can you play a fast game of tennis or other strenuous sport without becoming exhausted? | Easily | A |
| | Fairly well | B |
| | Get very tired | C |
| | Get exhausted | D |
| | Wouldn't try it | F |

| | | |
|---|---|---|
| 3. Do you jog or engage in some other very active exercise several times a week? | Usually | A |
| | Fairly Often | B |
| | Occasionally | C |
| | Seldom | D |
| | Allergic to exercise | F |
| 4. Are you fairly strong and physically able? | Very | A |
| | Moderately | B |
| | Adequate for my purposes | C |
| | Quite weak | D |
| | I can't stand up in a strong wind | F |

Diet:

| | | |
|---|---|---|
| 1. Are you overweight? (Just check to see how much surface fat is visible on your body.) | Not at all | A |
| | Mildly overweight | B |
| | Moderate amount of flab | C |
| | Quite a paunch | D |
| | Butterball | F |
| 2. Do you smoke? | Never | A |
| | 2 or 3 a day | B |
| | Half-pack a day | C |
| | Pack or more a day | D |
| | Chain smoker | F |
| 3. Do you drink liquor (including wine or beer)? | Rarely or never | A |
| | Socially and seldom | B |
| | One a day | C |
| | Several a day | D |
| | I'm an alkie | F |
| 4. Do you drink coffee, tea, cola drinks, or other sources of caffeine and sugar? | Rarely or never | A |
| | 1 or 2 a day | B |
| | Several a day | C |
| | Regularly, including with meals | D |
| | Can't do without it | F |

Interpretation: Assign 4 points for an A, 3 to a B, 2 to a C, and 1 to a D. Add up your points and divide by 12. How do you rate? A, "B+", or better means you're in good shape with three of the essential stress management ingredients. Anything less and you should be looking to change the areas(s) of your weakness.

# MODIFYING THE PRE-SCHOOL ENVIRONMENT TO MEET THE NEEDS OF THE SEIZURE DISORDERED CHILD

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The terms convulsive disorders, epilepsy, and seizure disorders are often used interchangeably to describe the same condition. In general, these terms refer to excessive and irregular neural discharges in the brain resulting in physical reactions ranging from loss of consciousness and massive convulsive movement to momentary cessation of activity.

The recent shift of public schools to providing services for younger disabled children and a similar realignment by private preschools has brought an increased number of children with seizure disorders into the classroom. Previously, many of those children would have outgrown the condition or the seizures would have stabilized prior to entrance into school. Although these children present many of the learning and emotional problems present in other disabled children, their seizure patterns require teachers to employ additional safety precautions and modifications of classroom environments.

Howell (1978) estimated that one-half of a percent to two percent of the population are subject to reoccurring epileptic seizures. However, estimates for children run notably higher (Jabbour, Duenas, Gilmartin, and Gottlieb, 1976). Studies have also shown that the retarded and institutionalized populations exhibit a substantially higher frequency of seizures than the general population (Richardson, Koller, Katz, and McLaren, 1981).

Successfully modifying the preschool and elementary environment for the seizure disordered child revolves around extensive preparation prior to the placement. The preparation should be initiated by gathering of facts concerning the child's capabilities, limitations, and functioning. From this information,

a plan for staff training, peer awareness, environmental and curricular modification, ongoing evaluation, and parental interaction should be developed.

## Staff Training

Children exhibiting seizure disorders exhibit learning and behavior problems often associated with other groups of children. However, seizure disordered children present numerous problems which are distinct from non-handicapped children and from those children that have significant intellectual or physical handicaps.

The more severe the seizures exhibited by the child or the larger number of children with seizure disorders placed in the classroom and the school, the more inclusive staff training should be. This training should include an orientation to appropriate terminology, medical and parental concerns, awareness and detection of seizures, curriculum concerns, and emergency and evacuation procedures.

### Terminology

Involved in an adequate staff training program must be an orientation to education and medical terminology used to describe the differing manifestations of symptoms. Many of the traditional terms which are in common usage are gradually being replaced by an international classification system. This system uses terms which are descriptive rather than just labels (Levine, 1977). The definitions found in Table 1 are words which are common usage. These terms seem critical if parent interaction, staff understanding, and inter-agency communication are to be facilitated.

TABLE 1 ON NEXT PAGE

Table 1

Common Terminology and Definitions for

Seizure Disorders

| Term | Definition |
|---|---|
| Absence Seizures | a seizure characterized by a loss of consciousness for 5 to 15 seconds. |
| Akinetic Seizures | sudden loss of muscle tone usually lasting a maximum of 60 seconds. |
| Aura | a warning often preceeding a seizure. characterized by various symptoms. Warning symptoms tend to remain the same for an individual. |
| Autonomic Epilepsy | see Hypothalamic Epilepsy |
| Convulsive Disorder | see Seizure |
| Epilepsy | see Seizure |
| Focal or Cortical Seizure | convulsions originate in the cortical areas resulting in motor, sensory, psychic, or visual abnormal functionings. |

Table 1

continued

| Term | Definition |
|---|---|
| Generalized Seizures | seizures occurring bilaterally symmetrical and without local onset. |
| Grand Mal | generalized seizure characterized by loss of consciousness, tonic (stiffening) and clonic (jerking) usually followed by confusion and drowsiness. |
| Hypothalamic Epilepsy | seizure activity characterized by recurrent complaints such as headaches, dizziness, nausea, vomiting, palpilations, abdominal pain, and sweating. These may be accompanied by rage, involuntary crying, and/or laughing, illusions and emotional outbreaks. Usually diagnosed by a history of attacks and the ruling out of other syndromes. |

Table 1

continued

| Term | Definition |
|---|---|
| Infantile Seizures | see Myoclonic seizures |
| Jacksonian Seizure (March Seizures) | tonic-clonic movement of limb or face muscles, usually one side of the body. May last up to several hours. |
| March Seizures | see Jacksonian Seizures |
| Mixed Convulsive Disorder | a combination of focal motor and psychomotor convulsions with generalized convulsions. Common ages 2 to 10. |
| Myoclonic Seizures | seizures characterized by a very sudden and rapid symmetrical flexion or extension of head, trunk, or limbs. Often found in association with mental retardation. Most often occur age 3 to 12 months. |

Table 1

continued

| Term | Definition |
|---|---|
| Partial Seizures | seizures beginning locally |
| Petit Mal | a limited discharge of the neorons. Commonly exhibited are arrest of activity and loss of consciousness for 5 to 30 seconds. |
| Psychomotor convulsions | bizarre, unpredictable combinations of motor, sensory, autonomic or psychic behaviors lasting from minutes to hours. |
| Seizure | an episode of uncontrolled electrical activity in the brain, neuronal discharges become excessive and irregular. |
| Seizure Equivalent | see Hypothalamic Epilspsy |
| Status Epilepticus | repetitive tonic-clonic seizure activity so severe that the individual requires hospitilization and lifesaving intervention. |

Table 1

continued

| Term | Definition |
|---|---|
| Tonic-Clonic | stiffening-jerking. See grand mal. |

The above list should serve as a point of embarkation for preparing co-workers to more appropriately deal with children who have seizures. The list could well serve as a handout for such in-service training as well as being available to help provide information to parents and being a reference guide when reading medical reports. Jabbour, et al., (1976) and Levine (1977) provide rather complete discussions of terminology and the classification system.

Emergency Procedures

The training in first aid and the understanding of emergency procedures are critical aspects of preparing school staff for dealing with the seizure disordered individual (Williams, 1979).

First aid procedures should include training on procedures to take during and after a seizure. The following procedures were suggested by Dener and Knapcyzk (1980) and seem to be important points in any school setting:

1. During a grand mal seizure, make sure that the learner is lying on his back with his head turned toward one side; move objects on which he might hit his head from the vicinity; do not put anything in his mouth. When a seizure is over, let him lie quietly or even sleep for a while.

2. After a grand mal seizure, begin artificial respiration if learner shows signs of a lack of oxygen, e.g., cyanosis. Because it may be difficult to tell when a seizure has ended, mouth-to-mouth rescusitation is not recommended. If teacher does not have the training necessary to use artificial respiration, get medical help immediately.

3. If the learner defecates or urinates in his pants during a seizure, make sure he is cleaned up to avoid embarrassment.

4. In most situations, the school medical staff will monitor medication. Do not give any medication for which there is not authorization by a physician on file, but make sure that all authorized medication is taken on schedule.

5. Keep accurate records of all medication given: date, time, amount.

6. If the student appears to miss information, repeat it.

7. Keep records of the dates, number, severity, length, and type of seizures for physician's reference.

8. Remember that a learner who is heavily drugged to control seizure experiences the world in slow motion. Do not confuse such a person by speaking too rapidly, or by trying to say a lot in a short period.

9. If the learner has seizures, make sure the physician rechecks his medication at least yearly. During puberty or any other times when seizures tend to change levels of frequency and intensity, medication levels should be checked more often.

It has also been pointed out (Williams, 1979) that one should never force an object into the student's mouth. It may also be of benefit for staff and parent to pay attention to behavior that traditionally precedes generalized seizures because they might offer pre-warning for staff to prepare for a seizure.

Staff should further be trained in artificial respiration. If the total staff cannot be trained in such practices, then a qualified person should always be available and on site when children with seizure disorders are in attendance. It has been pointed out by Dener and Knapczyk (1980) mouth-to-mouth resuscitation is not recommended with seizure cases because of the difficulty in determining the termination of the seizure. Courses taught by the American Red Cross generally offer mouth-to-mouth and alternate forms of artificial respiration.

An emergency evacuation procedure should also be established and understood by the staff. The following components make up an adequate evacuation procedure: (a) phone numbers of the fire department, paramedic, or ambulance, parents, and the pediatrician posted by the telephone(s); (b) the route and destination of the evacuation; and (c) an attachable identification tag or card (if child has to be evacuated) which lists name and parent's telephone numbers, time seizure started, medication administered, parts of body involved, and when the seizure stopped - if it has.

These minimum procedures should be established for all school emergencies but especially if children with seizure disorders are enrolled. Both practice by staff members at the site and the invitation of the paramedic or ambulance crew to your site will insure the successful evacuation of the problem seizure case.

## Identification of Seizures

Although it is relatively easy to identify generalized seizures, many partial or petit mal seizures are often not identified in young children (Dener and Knapczyk, 1980). Children appear and perform perfectly normal functions except during a 5 to 30 second period when they are seizuring. During these periods they may miss information and appear to be unmotivated or less capable than they are (Dener and Knapczyk, 1980; Williams, 1979). The following checklist was developed (Dener and Knapczyk, 1980) to aid the adult observer to identify symptoms which may indicate seizure activity long present in a child:

1. Goes "blank" for short periods of time, i.e., eyes unfocused, blinks frequently.
2. Misses bits of information during the normal flow of events.
3. Hears, sees, smells, tastes, or feels things that others do not experience.
4. Complains of occasional or repeated numbness or pain in specific parts of the body.
5. Occasionally exhibits strange or bizarre behaviors, especially if he does not remember doing so.
6. Drops objects for no apparent reason.
7. Exhibits tics, trembling, or rhythmetic movements around the mouth, eye, extremities, or other body parts. (P. 199)

If it is suspected that partial seizure activity is being manifested even when major concern has been expressed over grand mal activity in a child, contact with the parent of the child should be made and they in turn should contact their neurologist. Such symptoms also indicate the need for modification of teaching approaches in many cases. These modifications will be discussed further but should include the necessity for asking questions and the understanding that there may be numerous periods that the child appears to be daydreaming or not listening.

## Medication

Individual staff members who are in direct contact with the child who is being given anti-convulsant drugs should be trained in the administration and

effects of such drugs. This is an ideal time to include the parent in such training. The parent can describe both the proper dosage and the proper method to induce cooperation in the child along with how the child's seizure and social behavior are modified by drugs. Table 2 is provided to aid in understanding of some of the more common anti-convulsant drugs, their indicated usage, and the side effects they cause.

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TABLE 2 ON NEXT PAGE

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Table 2

Common Anti-Convulsant Drugs

Indicated Use and Side Affects

| Drug | Indicated Use | Side Effects |
|---|---|---|
| ACTH | Infantile spasms | |
| Celontin (Methsuximide) | Petit Mal<br>Psychomotor<br>Myoclonus | Skin rash<br>Nausea<br>Vomiting<br>Ataxia |
| Dexedrine | Petit Mal | Hyperactivity<br>Anorexia<br>Insomnia |
| Diamox (Acetazolamide) | Myoclonic seizures<br>Petit mal<br>Generalized | Lethargy<br>Ataxia |
| Dilantin (Diphenylhydantoin) | All seizures, except Petit mal | Gum hyperplasia<br>Rash<br>Nystagmus<br>Ataxia<br>Lethargy<br>Leukopenia<br>Thrombocytopenia<br>Hypertrichosis |
| Gemonil (Methbarbital) | Infantile spasms,<br>Myoclonic seizures | Drowsy<br>Ataxia |
| Mebaral (Mephobarbital) | Generalized focal seizures | Drowsy<br>Ataxia<br>Irritable |

Table 2

continued

| Drug | Indicated Use | Side Effects |
|---|---|---|
| Mysoline<br>Primidone | Generalized psychomotor, except petit mal | Drowsy<br>Ataxia<br>Vomiting |
| Phenobarbital | All seizures | Drowsiness<br>Hyperactivity |
| Tegretol<br>(Carbamazephine) | Psychomotor | Leukopenia<br>Ataxia<br>Lethargy |
| Tridione<br>(Trimethadione) | Petit Mal | Rash<br>Photophobia<br>Drowsiness<br>Nephrosis<br>Aplastic anemia |
| Valium<br>(Diazepam) | Myoclonic seizures<br>Generalized<br>Status epilepticus<br>Petit Mal | Lethargy<br>Ataxia |
| Zarontin<br>(Ethosuximide) | Petit Mal<br>Psychomotor | Vomiting<br>Rash<br>Ataxia<br>Lethargy |

Table 2 should serve as a reference when preparing staff and for educational programming. It should be noted that there are other drugs and numerous trade names which are prescribed for seizure disordered children and that these drugs are often prescribed in varying dosages and combinations. Individual children often show unique reactions to specific drugs or combinations or drugs. The parent and physician should be consulted in reference to expected and observed side effects of medication.

## Modifications

As indicated, the children with seizures often exhibit learning and behavioral problems which require attention on the part of the school personnel that other children often do not. Consideration by the direct care and classroom personnel should be given to the physical environment and the curricular concerns. The seizure disordered child may require modifications to be made to the existing physical setting. This determination can best be made by observations of the child. Observations on several different days is probably most beneficial. A structured observation for three to five minutes of the child when left in a room alone, alone with toys, and in interaction with an adult or peers. The observer should record how seizure activity and medication effects (a) attention, (b) balance and stability, (c) mobility, and (d) activity level of the child. Special attention should be given to the checklist developed by Dener and Knapczyk (1980) in determining if partial seizures are affecting attention, balance, or mobility.

Structured observation should in no way displace the importance of parental input. A portion of the admission interview or information gathered for and during the Individual Education Program development should include specific information concerning the functioning child in reference to attention and mobility.

Both observation and information gathered from parents should indicate if environmental or curriculum modification are needed and if so, the direction of those needs.

Environment

The nature and magnitude of environmental modifications are determined by severity and/or number of seizures manifested by the child. The nature of these modifications revolve around providing a safe learning environment for the child can be evaluated by observing the ability of the child to move and function independently in the total setting (Baker, 1980). Consideration should be made as to the safety of the child's assigned work area, the general classroom, the play, and the recreation areas. The major consideration is protection of the child during seizure activity.

Areas which the child works, i.e., floor area and assigned desk should be scrutinized. Many serious injuries can be prevented by fitting the child with a helmet. Many of the newer and custom fit helmets offer protection to the nose and face. However, even with a helmet it may be necessary to carpet or pad the floor area around the seat and elements or pad hard surfaces and edges to lessen injury to other body parts.

Although the issue of safety and emergency procedures should be addressed during staff training, a conscious assessment of areas needing close supervision and possible modification of the child's experiences should be considered when the child is placed in the classroom. Clearly the concern for safety must prevail the entire program.

This is not to say that normal activities should be eliminated; but, on the other hand, all settings should be assessed for hazards and modified to protect the child or close supervision must be offered. This is especially true in high risk areas such as the swimming pool and electrical power equipment (Williams, 1979).

The other modification that provides increased safety is the provision of the helmet. A properly fitted helmet can reduce the incidence of facial abrasions and crainal injury in these children. In turn, the helmet allows the seizure disordered child to move about automously and reduces the need for one

to one supervision in many previously identified high risk areas. Several brands of commercial produced helmets are on the market. A physical or occupational therapist can aid the parent and/or school in such a selection. In severe conditions, an individually fitted and produced helmet may be purchased. The larger cities in our nation usually have companies which specialize in such head gear. State agencies dealing with the Developmentally Disabled can aid the family and school in contacting such companies.

Curriculum

Modification of curriculum again depends on the nature and extent of seizures. However, there are two areas that must be addressed when assessing the need for curricular changes. These are the safety of the child in the educational setting and the facilitation of the effective learning for the child.

George Stores (1975; 1978) points that research consistently demonstrates that learning and behavioral problems are over-represented in the seizure disorder population. Although the majority of his summary relates to school children in Britain, the conclusions seem to generalize to this population in America. These research findings include (a) boys with seizure disorders exhibited depressed scores in reading accuracy and comprehension when compared to non-seizure disordered boys; (b) seizure disordered children had worse scores on measures of distractability than non-seizure disordered children; (c) seizure disordered boys exhibited high levels of anti-social behavior, anxiety, overactivity, and social isolation than did other children; and (d) seizure disordered boys showed higher need for affection and presence of their mothers than their peers. This research was conducted on relatively small samples and on children above the pre-school age; however, seemed to be validly conducted and offers some considerations for the school setting. These considerations include that a seizure disordered child (especially if he is a boy) may need increased attention and more sophisticated individualized programs.

The teacher and parent must be aware of potential learning problems and behavior problems. The educator must be willing to modify teaching methods and materials when such change is indicated by a child's functioning.

The curriculum and teaching approaches must also reflect flexibility due to the effect of anti-convulsant medications on the child's behavior. First, different children react differently to the same drug depending on their biochemical system. Second, the same child may react differently depending upon variable factors such as sleep and nutrient intake and third, although the drug(s) is targeted for the brain, its thorough absorption affects the total body (Hawkin and Zuna, 1963).

The above three realities of drug therapy have direct implications on behavior and, therefore, teaching approaches. Those effects can be summarized by the statement the seizure disordered student may exhibit behavior that is changeable and at times unpredictable. Beyond this is the consideration that any time a medication is changed or added, behavior manifestations must be monitored closely because of a high probability of change in these behaviors caused by the drugs.

The parent and/or physician should be consulted in these instances. The parent often is the best source of information, both on a general and a daily basis and should be encouraged to provide the teacher with factual reports to expected behavior.

A close scrutiny of Table 2 will reveal that all of the drugs used as anti-convulsants for the pre-school and younger school age population produce notable side effects. The majority produce hyper or hypo activity in children. This fact reflects the possible need to present information in differing manner or at a pace which may not be the same as other children in the setting.

Finally, the teacher should note that medication and/or seizure activity may reduce the amount of information that a child may receive at given periods (Dever and Knapczyk, 1980). The detection of seizure activity should indicate to

the teacher to be aware of possible reduction in processing by the child. By using the checklist developed by Dever and Knapczyk (1980) which was discussed earlier and parental input, the teacher may evaluate whether information should be repeated, presented in another way, or postponed for a more appropriate time. These skills can be developed with practice if they practice observational techniques.

## Peer Awareness

Successful placement of the child with seizure disorders also involves preparing other students in the classroom and school to understand the nature of seizures. This includes the fact that individuals who have a seizure is neither in pain nor injured (Williams, 1980). The Epilepsy Foundation of America will provide free teaching materials which enhance peer awareness.

## Ongoing Evaluation

A clear need in providing appropriate service for the seizure disordered child is on ongoing evaluation system. Such a system can provide the staff, the parent, and the physician with information which can make the child's life and education fuller.

The structure of this system should revolve around a charting/recording system. Pertinent information to be gathered should be worked out with all parties involved. The following suggested list should be evaluated in each child's case: the type of seizure, the duration of individual seizures, the time of occurrence, the number of seizures per day, hour, and minute, and changes in behavior and attention. Information gathered should be comparable to averages obtained during previous periods. A good system will reflect effects of medication, diet, emotional factors, and teaching techniques. The level of sophistication will depend upon staff understanding of the importance of data and their staff observational skills. Both factors should be addressed and monitored by school or program administrators and included in ongoing inservice training.

## Parent Interaction

One of the most critical and often overlooked aspects of providing effective service to the seizure disordered child is parent interaction with the staff and teachers. Parents are highly effective and skilled observers of their children (Barsch, 1968). By facilitating parent communication with school personnel, planning for curriculum and activities can be improved. Also, parents can be included in every aspect of the program, especially staff training, peer readiness and the ongoing evaluation system. In fact, the parent can either help structure the majority of these activities and/or serve as a primary resource.

It is important to continue communication after the child has been placed in the educational setting. The use of the notebook that the child can carry to school and home is one method of maintaining this communication. By providing a structured format which could include seizure activity for the day, food intake, abnormal behavior, and sleep during the period, useful and specific information can be relayed between school staff and parents. Other information which is pertinent to the specific problems of the child should also be included in this format. Telephone calls or daily discussions between staff members and parents may supplement or replace the notebook approach.

A final consideration of parental interaction is the direct involvement of the parent in classroom activities. The parent may serve as a useful aid in the classroom especially during the initial placement of the child. Because of the parent's extensive knowledge of how to present information and control behavior the parent may be able to train staff effectively and rapidly. The parent may also be extremely helpful on field trips and during activity periods to insure safety and complete experiences for the child.

## Summary

The numbers of seizure disordered children being served in public and private preschools are increasing. Effective and appropriate education service to the young child with this form of disability is a process which involves

planning and time often not required to offer the same level of experience to a non-seizure disordered child. The structure for such an effective program should be based on an overall plan for staff training, environmental and curriculum modification, peer awareness, on-going evaluation and parental interaction. To insure that such a plan is carried out, a checklist of specific essential areas of the overall plan should be developed. Appendix I is offered as a summary and as an example of such a checklist. Modifications of such a checklist can and should be made to meet the needs of the individual student and education facility.

Appropriate services for this class of handicapped children requires a committment by all staff members who are involved in the education of the child and the addressing of each of the noted areas by the staff and administration of the educational site. If this is done, children with seizure disorders will be able to be offered complete educational experiences.

Appendix I

Seizure Disorders

Important Information

Checklist

Pre-entry:

____ Medical

____ Parent Interview

____ Structured Observation

____ Doctor Contact

Staff Training:

____ Terminology

____ First Aid Procedures

____ Evacuation Procedures

____ Identification of Seizures

____ Medication and Side Effectis

Modifications:

____ Observation of the child in classroom

____ Observation of child in recreation

____ Observation of child in other settings

____ Evaluation of need for helmet

____ Curriculum individualized to child

____ Administration of medication established

Appendix I

continued

Ongoing Evaluation:

____ Charting observational system established

____ Monitoring of system established

Peer Awareness:

____ Training prior to placement

____ Established statement during seizures

Parental Interaction:

____ Inclusion in staff and child training

____ Two-way communication system established

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# HOW THE WISP WAS WON:
# A MODEL OF SERVICES FOR
# HANDICAPPED INFANTS AND TODDLERS

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Karnes (1973) has suggested that one of the most universally accepted propositions is that the earlier one can provide treatment resources to the handicapped child and his/her family, the greater the chance of maximizing the child's potential. In concert with this thinking, during the past decade there has been a surge in the development of programs for handicapped preschool children and their parents. As these programs evolved, there has been a move to develop specific programs for the youngest of these children; the handicapped, age birth to three years. One such program was the Wyoming Infant Stimulation Program (Project WISP), which operated as a HCEEP model-demonstration program from 1976-1979. The purpose of this paper is to describe this project and to present effectiveness data.

## Program Overview

The Wyoming Infant Stimulation Program (Project WISP) was developed for infants and toddlers with mild to severe handicaps, and the parents of these children, residing in Laramie, Wyoming, a significantly rural area. The program was also developed as a model for agencies intending to serve handicapped infants and toddlers.

The program was located in a facility which housed the Development Center for Preschool Children, Head Start and Community Day Care. This setting contributed to the "Least Restrictive Educational Environment (LRE)" as Project WISP children were able to "graduate" to any one of these three programs within the same facility.

Children and families served by the project represented all socio-economic levels and the larger percentage (99%) of this target group was Caucasian. The

age of the project children ranged from three months to 33 months at time of entry into the project. Of the 43 children served by the project, 15 were speech/language impaired, 14 were orthopedically impaired, five were emotionally disturbed, four were trainable mentally retarded, two were educable mentally retarded, two were health impaired, and one was visually impaired. Approximately 25 percent of these children were multihandicapped.

Project Goal/Objectives

The overall project goal was to facilitate the development of the target population so that they could function in the least restrictive environment. The overall project objective was that each child would progress according to his/her Individual Educational Plan (IEP) in the developmental areas of 1) social/emotional; 2) gross motor; 3) fine motor; 4) adaptive reasoning; 5) receptive language; 6) expressive language; 7) feeding; and 8) dressing and simple hygiene.

Theoretical Approach

The basic theoretical approach used in this project was developmental/prescriptive. By developmental, it was assumed that change occurs in a sequence and that decisions in programming can be made via an analysis of this sequence. Development in handicapped children is impeded either by a slow rate of development or some condition that actually is a barrier to development. Consequently, it was necessary to provide learning situations, either through direct instruction or providing learning experiences, to overcome the slow rate of development, or barriers to development. Each child's developmental skills (strengths and weaknesses) were defined by a comprehensive assessment of performance. Following this, an Individual Education Plan (IEP) was developed, with parent input and approval, for each child. An analysis was made to determine skills needed to reach the child's potential in each developmental area. Objectives were written and activities were developed to facilitate these objectives. The development and implementation of each child's program was facilitated by a trans-disciplinary staffing approach. An integral part of the model was a parent involvement program for the parents of project children.

Curriculum

The curriculum was organized into eight curricular areas (social/emotional; gross motor; fine motor; adaptive reasoning; receptive language; expressive language; feeding; and dressing/simple hygiene) and was eclectic in nature utilizing a developmental-prescriptive approach and variety of techniques, materials and activities as means of implementing each child's IEP. Based on staff review and decision, the major curriculum/activity sources were Performance Objectives for Preschool Children (Schirmer, 1975); Karnes Infant Curriculum (unpublished); and Portage Program (Shearer, 1976). Each of these curricula is developmentally based and their use has provided a unique blending of readily available materials.

Program Services

Program services were consistent with the implications and applications of Public Law 94-142 and exemplary intervention strategies for young handicapped children and their families. A review of these services is presented and these services comprised the program model (Figure 1).

Identification and screening. Referrals were accepted from a variety of sources and were stimulated by a wide range of dissemination efforts. As referrals were made, parents were contacted to sign a screening release form and to complete a short interview. The attending physician was notified of the referral. Each child was administered the Developmental Screening Inventory (DSI) (Knoblock, Pasamanick and Sherard, 1974) which provides screening data in the following areas: adaptive; gross motor; fine motor; language; and personal-social. Screening results can be converted to a maturity level for each of the developmental areas screened. Screening information was reviewed by the screening team, as consistent with P.L. 94-142, relative to referring the child for further testing to determine candidacy for enrollment into the project.

Intake and diagnostics. After the screening team determined the child's need for further testing, intake and diagnostic procedures were initiated. The intake and diagnostic procedures were administered by project staff and other profession-

## SERVICES TO CHILDREN

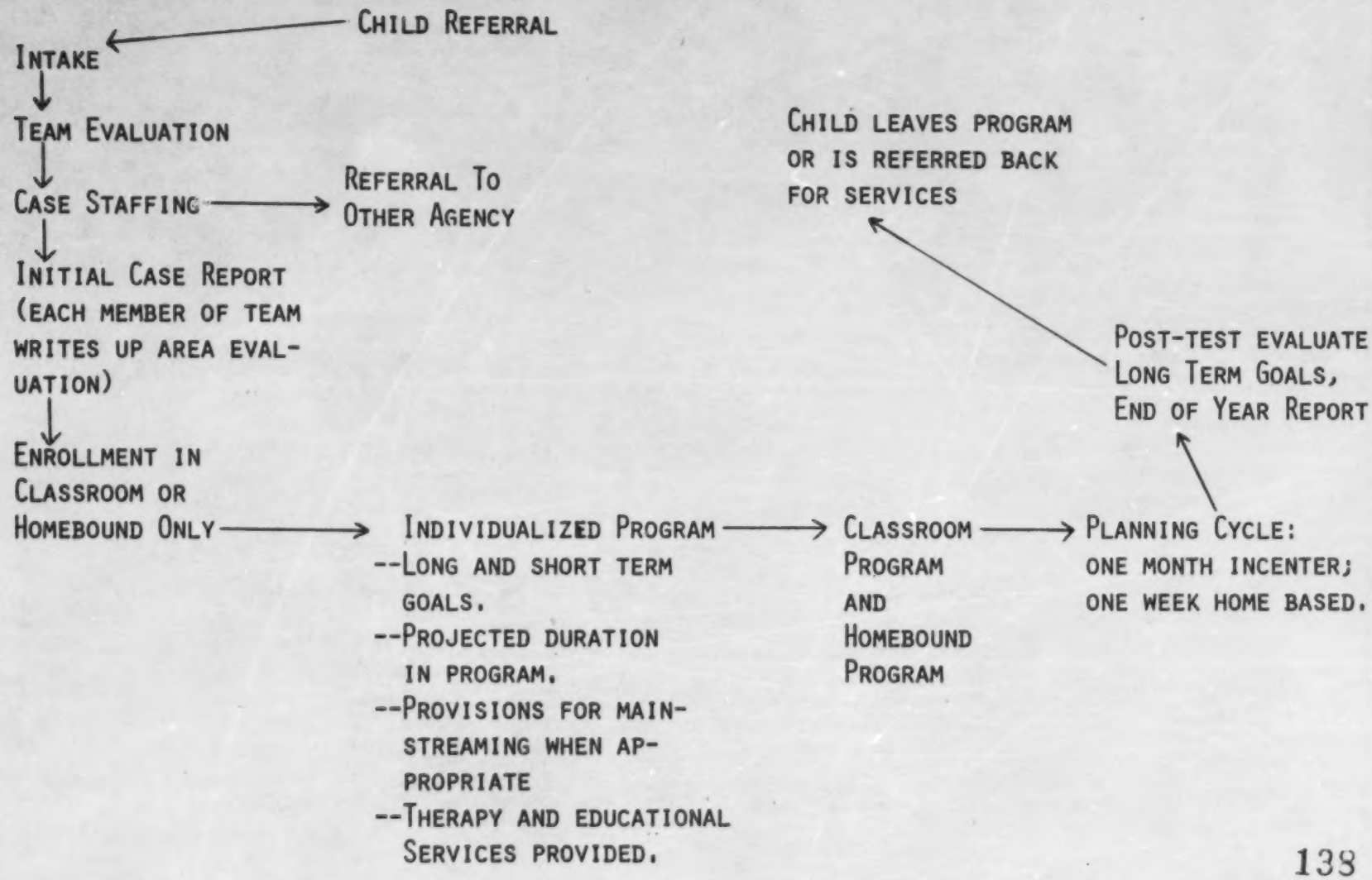
CHILD REFERRAL
INTAKE
TEAM EVALUATION
CASE STAFFING
REFERRAL TO OTHER AGENCY
INITIAL CASE REPORT (EACH MEMBER OF TEAM WRITES UP AREA EVALUATION)
ENROLLMENT IN CLASSROOM OR HOMEBOUND ONLY
INDIVIDUALIZED PROGRAM
--LONG AND SHORT TERM GOALS.
--PROJECTED DURATION IN PROGRAM.
--PROVISIONS FOR MAINSTREAMING WHEN APPROPRIATE
--THERAPY AND EDUCATIONAL SERVICES PROVIDED.
CLASSROOM PROGRAM AND HOMEBOUND PROGRAM
PLANNING CYCLE: ONE MONTH INCENTER; ONE WEEK HOME BASED.
POST-TEST EVALUATE LONG TERM GOALS, END OF YEAR REPORT
CHILD LEAVES PROGRAM OR IS REFERRED BACK FOR SERVICES





FIGURE 1.

als (e.g, certified audiologist and family physician). These procedures included: 1) indepth parent interview including pregnancy and birth history, the child's attainment of developmental milestones, the child's health history, aspects of the child's behavior, and familial history; 2) administration of the Sewall Early Education Development Program (SEED) (1975); 3) an otoscopic examination, impedance screening, and sound-field testing; and 4) physical examination - - any contraindictions were provided. If this battery could not be administered because of specific characteristics of the child, or diagnosis was not clear, other instruments (e.g., Bayley Scales of Infant Development (1969); Callier-Azusa (1975) were used).

Staffing. Subsequent to the completion of the intake and diagnostic procedures, a staffing was conducted to make final determination as to whether the child was appropriate for placement in WISP. All staff who particiapted in the intake and diagnostics process attended the staffing to discuss the child's strengths and weaknesses and to make placement recommendations. The child's parents were an important part of this conference as they were a significant resource in providing input into decisions. This staffing resulted in one of three recommendations: 1) placement in WISP; 2) referral to another agency which could more effectively meet the needs of the child and his/her family; or 3) no specialized services for either the child or his/her family. Pros and cons of the placement recommendation were thoroughly discussed with the parents and the assistance was provided to the parent(s) in implementing the recommendation. If the recommendation was for placement in WISP, and the parents supported this recommendation, an IEP was developed with parent and staff input.

Instructional methodology. Instruction was delivered in both home and classroom settings. Although instruction was delivered in either of these settings, the mode of instruction was the same. In other words, all children received the same testing. their programs were designed under the same goal structure, the same curricula were used, and the same types of activities were used. The weekly schedule of activities was designed for specific skill acquisition, as determined

by each child's IEP. The particular activities were taken from project curricula and were directly related to the eight curricular area assessed by the SEED. Additional specialized services (e.g., speech therapy, occupational therapy, or physical therapy) were provided for project children consistent with each child's IEP.

Each child's individualized program was reviewed on a regularized planning cycle. This planning involved staff review of the child's progress toward meeting his/her goals/objectives, and/or adding new goals/objectives at higher skill levels. The number of objectives set and met, and the percentage of objectives met were recorded quarterly and totaled at the end of the program year. At the end of the program year, post-testing was accomplished, progress according to the child's individual program was evaluated, and an end-of-year report was written. At this time, a determination of placement for the following year was made, based on the year-end evaluation and the age of the child.

Parent program model. Parent programming was an integral part of the Services to Children component. As children entered the program, their parents' needs were assessed by the parent program coordinator and an Individual Parent Program Plan was developed, based on these needs. The parent program encompassed four major areas: 1) social and emotional support; 2) exchanging information; 3) parent-child interaction; and 4) parent participation. The parent program was implemented via morning and evening group meetings/activities, parents volunteering in the program, home visits, and other activities according to the parents' individual needs. This model is presented in Figure 2.

## Project Effectiveness Data

### Description of the Sample

All the children who qualified for inclusion in the project were considered to be the sample. The criteria for accepting children into the program was a three- to six-month delay in one or more developmental areas for children C.A. 18 months to three years and a one- to three-month delay in one or more developmental

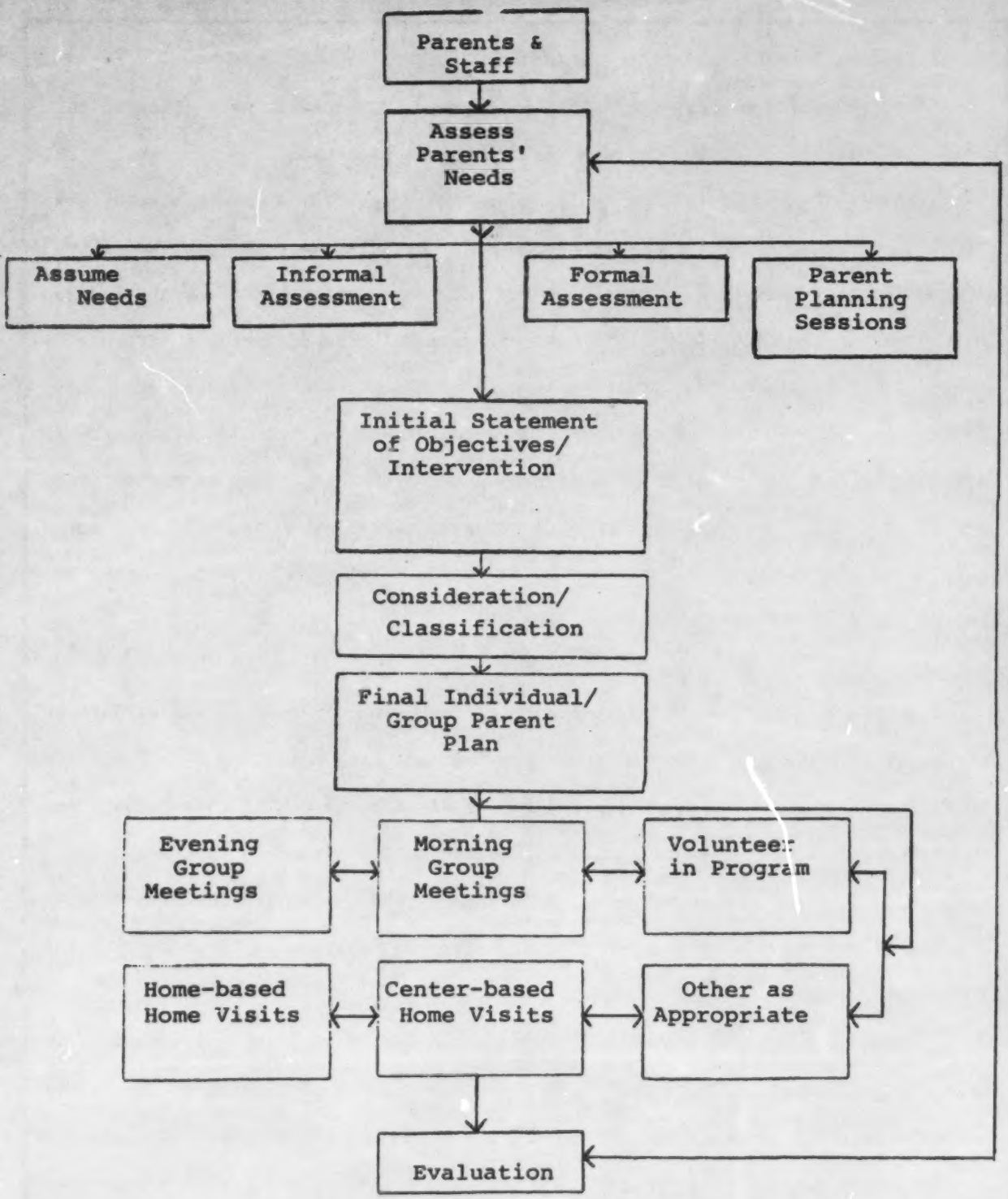


Figure 2: Cycle of WISP Parent Activities

areas for children C.A. birth to 18 months.

Of the 43 children served by WISP, both pre- and post-data were obtained for 38. The mortality of five subjects was due to the fact that they, and their families, moved before post-testing could be accomplished. These five subjects, however, were not different than the sample subjects relative to type or severity of handicapping condition. These children ranged in age from three months to 33 months old at the time of entry into the program. The handicapping conditions ranged from relatively moderate to severe in each of the developmental areas addressed by the program. Of the 38 children in the sample, two did not receive services in feeding and nine did not receive services in dressing/simple hygiene because such programs were not judged to be appropriate for those children. Accordingly, the sample size reported for those two curriculum areas is reduced to 36 and 29, respectively.

Measures

The SEED was administered by project staff who were trained in individualized assessment and various other testing. The instrument is comprised of 672 specific developmental tasks that are grouped into the eight Project WISP curriculum areas. The instrument is designed to identify specific skills and needs that are to be considered in program development of each child. The skills are identified by age levels and provide an age-functioning score, in addition to the record of specific performance.

Although the SEED was developed over a three-year period with systematic item selection, testing, and revision (including comparison with results of the Denver Developmental Screening Test), no empirical evidence of validity was compiled that could be presented for external review. Accordingly, a study to verify the validity was conducted as a part of Project WISP. In this study, the Developmental Screening Inventory (DSI) and the SEED were both administered to 24 project children to determine the concurrent validity of the SEED. These two instruments were administered at different times in the planning for the children's program.

The DSI data were collected as part of the screening and the SEED data were collected as part of the assessment following the screening program. Both instruments were administered individually by project staff. WISP staff were trained to administer DSI and SEED by individual experiences in the administration of these instruments.

Evidence of the validity of the DSI was reported by its authors (Knoblock, Pasamanick, and Sherard, 1966). When the DSI scores were compared with the Gesell scores, the correlations ranged from .94 to .98. Table 1 displays this data

TABLE 1.

Correlations Between the Subtests of the Developmental Screening Inventory (DSI) and the Gesell -- Reported by Knobloch, Pasamanick, and Sherard, 1966 (N = 58)

| | |
|---|---|
| Adaptive | .97 |
| Gross Motor | .98 |
| Fine Motor | .94 |
| Language | .97 |
| Personal/Social | .97 |

The DSI and SEED subtests do not correspond exactly, but the similarity is sufficient for the subtests of the DSI to serve as validity criteria for the subtests of the SEED. The correlations obtained between SEED and the corresponding DSI subtests range from a low of .84 to .94. It should be noted that all subtests that correspond most closely in respect to the trait measured have correlations that are over .90. This data is shown in Table 2.

TABLE 2.

Correlations Between Subtests of the SEED and the Most Similar Subtests of the DSI (N=24)

| SEED | DSI | r |
|---|---|---|
| Social/Emotional | Personal/Social | .93 |
| Social/Emotional | Adaptive | .85 |
| Gross Motor | Gross Motor | .93 |
| Fine Motor | Fine Motor | .94 |
| Adaptive Reasoning | Adaptive | .85 |
| Receptive Language | Language | .94 |
| Expressive Language | Language | .90 |
| Feeding | Personal/Social | .84 |
| Dressing/hygience | Personal/Social | .91 |

## Design

The one group pre-test, post-test design was utilized. Although this design is particularly vulnerable to threats to internal validity, it was the design of choice considering the mission of HCEEP projects, the implications and applications of P.L. 94-142 disallowing withholding treatment from individuals/groups, and the very nature of rural, sparsely populated areas which preclude large populations for sampling, or groups for matching relative to different modes of treatment. Consequently, several rival hypotheses could be posed; however, the major rival hypotheses appears to be -- were the gains shown due to treatment effects or simply to maturational effects? Compensation for maturational effects was provided for, however, by using predicted scores as a control.

## Data Collection Procedures

The SEED was administered twice a year. The initial administration occured during the diagnostic part of the service system following the developmental screening; final administrations occured during the final month of the project service year. Data were collected by project staff certified in testing. Data for each child was then converted into an age-functioning score for each of the eight subtests of the SEED and specific performances were recorded. In turn, these data were summarized in an initial and end-of-years report for each child. The data assisted in identifying specific skills and needs that were considered in program development for each child, which in turn was implemented via the developmentally-based curriculi.

## Analysis

To determine program outcomes, estimates were made of the maturational effects which were then compared to the actual development of children after an average of approximately six months of service by the program. Specifically, child performance was measured with the SEED prior to their entry into the program. For each category of behavior measured by the SEED, a least-squares equation relating developmental age to chronological age was derived.

Under the assumption that without program services these children would continue to mature, an expected developmental age (or post-test score) was calculated for each child on each SEED subtest. This expected developmental age was then compared with the measured developmental age at the end of the program, or the predicted post-test score was compared with the actual post-test score, by using a t-test for dependent data. By using these predictions, the effects of maturation were controlled.

The .01 level of confidence was chosen to indicate significance for both of these methods of analysis.

Results

The correlation between developmental age and chronological age ranged from .70 to .85, with all correlations being significant at ($p < .01$), which justified using age as a predictor. In the study conducted to compare actual growth to the estimated growth for the total sample, significant gains ($p < .01$) were found in all curriculum areas, indicating that the Project WISP program is effective in producing significant child growth for children like those served by the project. Data related to this claim are presented in Table 3.

The gains indicated by this study are educationally significant for this population of children. The total group of children increased more than would have been expected in projected developmental growth. The criterion for change was stringent in that "change" meant that a child's rate of growth increased significantly over the rate of increase occured after an average of only about six months of programming. On all subtests, project children, as a group, actually gained one month per month in the program; on half of the subtests, these children displayed a mean gain of nearly two months per month in the program.

Some anecdotal data can serve to emphasize the importance of the effects of WISP. As has been mentioned earlier in this report, services to handicapped populations can address either slow rates of development or barriers to development. Some examples are:

TABLE 3.

Comparison of Actual and Estimated Performance and Growth in Months

| SEED | N | Pretest | Posttest | Predicted Posttest | Predicted Growth | Actual Growth | D | t* |
|---|---|---|---|---|---|---|---|---|
| Social Emotional | 38 | | | | | | | |
| Mean | | 14.5 | 24.5 | 19.3 | 4.8 | 10.0 | 5.2 | 6.6 |
| S.D. | | 8.4 | 12.8 | 7.9 | | | | |
| Gross Motor | 38 | | | | | | | |
| Mean | | 16.0 | 23.2 | 19.6 | 3.6 | 7.2 | 3.6 | 5.0 |
| S.D. | | 11.3 | 12.5 | 8.5 | | | | |
| Fine Motor | 38 | | | | | | | |
| Mean | | 14.3 | 22.1 | 17.7 | 3.4 | 7.8 | 4.4 | 6.7 |
| S.D. | | 7.8 | 10.6 | 6.6 | | | | |
| Adaptive Reasoning | 38 | | | | | | | |
| Mean | | 15.4 | 23.7 | 19.2 | 3.8 | 8.3 | 4.5 | 6.3 |
| S.D. | | 9.2 | 12.2 | 7.5 | | | | |
| Receptive Language | 38 | | | | | | | |
| Mean | | 13.0 | 23.0 | 16.1 | 3.1 | 10.0 | 6.9 | 5.1 |
| S.D. | | 8.7 | 14.6 | 6.5 | | | | |
| Expressive Language | 38 | | | | | | | |
| Mean | | 10.9 | 19.8 | 14.0 | 3.1 | 8.9 | 5.8 | 5.4 |
| S.D. | | 7.1 | 11.5 | 5.4 | | | | |
| Feeding | 36 | | | | | | | |
| Mean | | 17.9 | 28.8 | 21.7 | 3.8 | 10.9 | 7.7 | 6.5 |
| S.D. | | 11.0 | 14.6 | 8.8 | | | | |
| Dressing/Hygiene | 29 | | | | | | | |
| Mean | | 19.4 | 29.9 | 23.5 | 4.1 | 10.5 | 6.4 | 5.3 |
| S.D. | | 9.9 | 12.5 | 9.2 | | | | |

*t($\underline{p}$ .01) = 2.72 Thus all obtained values of t would have a "chance" level of less than .01. $\bar{X}$ of stay in program: six months. Range of age at entry: three months to 33 months. $\bar{X}$ of age at entry: 17.95. SD of age at entry: 9.64.

Child A. This child entered WISP at age 26 months functioning a year below age in motor skills and generally demonstrating mild delays in language and social skills. Bayley Mental Development Index (MDI) indicated an IQ score of 153, however. After nine months of programming the Bayley score was 161 and SEED scores indicated from one to two years of growth in all curriculum areas, with social/emotional functioning changing from 21 months to 52 months, and both expressive and receptive language changing from 24 months to 48 months. Such gains were possible because this child was an extremely gifted child intellectually, but with barriers to development that could be removed through WISP programming.

Child B. This child was severely delayed at the time of entry into the program at 38 months. Language and social development resulted in performance at the 10 to 13 month levels. Bayley MDI and Psychomotor Development Index (PDI) were 63 and 95 respectively. Seven months later, these Bayley scores were 109 and 113 and social functioning was 42 months with language performance increased by 14 months.

Further indicators of the educational significance of WISP effects are the placements of children in educational programs following Project WISP program participation. Project WISP staff were able to track 17 of these children. Three of these children are attending regular public school kindergarten with no resource help; three are attending regular preschool with no resource help; three are attending regular preschool with resource help; one is in a public school special education class; two are in preschool special education programs; and five are placed in no education setting, but parents report they are "doing fine."

## Summary and Conclusions

An overview of the Wyoming Infant Stimulation Program (Project WISP) model has been presented. Effectiveness data was analyzed for 38 subjects, age three months to 30 months, displaying moderate to severe handicaps. These children were assessed by the SEED twice a year - - on entrance to the program and at the end of the program year. Program data indicated that the Project WISP program

was effective in producing child growth in all developmental areas ($p < .01$). The educational significance of the intervention program was also documented. Overall, it can be said that this program did make a difference in maximizing the potential of the young, handicapped children it served.

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Project Funded by USOE/OSE/HCEEP Grant OEG # 0076602071

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# ASSESSMENT AND EVALUATION TECHNIQUES WITH INFANTS AND YOUNG CHILDREN

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Those of us involved in providing early education have been made aware of the significance of that time period prior to entry into kindergarten. In fact, research now points to the importance of infancy and the potential for learning during this time. This concept has particular relevance for those of us providing services to young handicapped children, for it implies that the earlier we can screen and identify children with handicaps, the more we can influence the development of a handicapped child.

For children with certain kinds of handicapping conditions, identification can occur at birth--for instance, children with physical anomalies such as microcephaly, cleft palate, most Downs syndrome children. Other handicapping conditions may be noticed during the first few days following birth. However, a number of conditions are not visibly evident and escape identification early. If we are to find and serve this group of children, we must be able to identify them from the population, and screening is one way in which we can accomplish this.

Screening is one way of testing a large population in order to identify those individuals who are most likely to manifest a handicap. Because of state mandates, communities conduct mass screening of preschoolers. It is the formal procedure for identifying people with suspected handicapping conditions. Screening is not--or should not be--used to label an individual, nor is it used to prepare specific objectives for intervention. A more intensive and complete assessment must follow for those individuals identified through the screening process.

We have other instances of established screening techniques that are in common practice today. One example is the screening for PKU (phenylketonuria)

which is mandated by law in many states. PKU is a congenital disease due to defect in metabolism of the amino acid, phenylalanine. This condition results in mental retardation and other abnormalities.

Considerable work has been done to develop other infant screening devices that can be used by pediatricians and other medical personnel to identify very young high risk children. Examples are:

1. The Developmental Screening Inventory (DSI)
2. The Developmental Profile
3. Probably the most frequently used screening test is the Denver Developmental Screening Test. This is a screening device that medical personnel can use to determine whether a child has developmental deviations. It measures child growth in areas of gross motor, language, fine motor adaptive skills, and personal/social skills

There are a number of screening instruments on the market today and professionals will agree that there is no ONE or perfect screening device. Despite difficulties encountered with existing devices and the need to go on working to develop better alternative methods of screening, there is no doubt that almost any kind of screening now in widespread use is better than no screening effort. For those children who are identified as needing further assessment, screening is the beginning toward the development of services for the child. We attempted to compile for you a list of screening and assessment tools, along with specific areas they address. It is our hope that this might assist you in selecting a tool for your particular need. After we have screened a group of children, the next step is assessment.

Assessment

Assessment is usually considered to be the complete and exhaustive pinpointing of an individual's skills and deficits and indicated for all children who are identified as potentially handicapped. As with screening, the results of assessment should not be used to label individuals, but to prepare appropriate intervention strategies.

Most of us would probably agree that under ideal conditions, as assessment

of any child would be divided into areas such as speech/language, motor, etc., and trained professionals would administer the area of their expertise. Realistically speaking for most of us, less than the ideal is generally in practice. In many instances we find professionals have not been trained in assessing or treating young handicapped children. There is widespread controversy within the disciplines regarding procedures and techniques appropriate for young children and a need to recognize the limitations of existing test procedures used with young children. We need to be keenly aware of the possibility that if we inappropriately assess a child the consequences could be devastating, whether that child is denied an appropriate education or is mislabeled. We as professionals must be willing to assure appropriate services for the handicapped child.

General Principles in Choosing an Assessment Tool

Generally speaking, many different assessment tools have been developed for use with different age levels and different populations. As we begin to look at assessment tools, we need to be aware of some background.

A formal assessment tool that includes many items will take longer to administer, but provide more precise information on the child's current functioning ability. A tool that includes a smaller number of items will be easier to administer, but may not give enough information around which to develop long- and short-term objectives. Each teacher needs to establish her own priorities and decide which tool will best fit the need of the children and/or the classroom.

No one assessment tool is going to be "THE ANSWER." The prime rule to remember at this point is that rather than reinvent the wheel and build a new assessment tool for each child in the classroom, select one tool which can give you reasonable information on most of your children, then adapt the tool as necessary to provide you with as much information as you need for each child.

The real acid test of an assessment's effectiveness lies in how well it serves the particular population and program for which it was designed.

Specific areas to look at when choosing assessment tool:

- Skill areas covered (communication, receptive language, self-help, ADL, motor skills, pre-academic, pre-vocational, leisure skills, personal/social copying)
- Items behaviorally stated (movement cycle can you count it)
- Criteria based (yes/no)
- well sequenced
- Translate well into goals and objectives
- Adaptable to other handicapping conditions
- Easily administered
- Expense
- Materials (do you have all the materials needed to assess)

Let's talk a minute about assessment. As a child comes into a program for the first time, the teacher must find out where the child is in relation to the rest of the class/or family members. The teacher has read through previous records of the child (if these are available), she/he may have already talked with the child's parents, previous teachers, physician, or other individuals who have dealt directly with the child. As a result of this information, the teacher has some basic background on the child (i.e., the child is ambulatory, not toilet-trained, has no language.) As helpful as this may be, it does not provide enough information at this point around which to build an instructional program. The teacher must do some type of initial assessment soon after the child enters the program.

Assessment should take place both on a formal and an informal basis. (overhead here) The first few sessions that the child is in the program should be a time of informal exploration for the pupil and observation for the teacher. The child is given a chance to interact with the environment on his/her own terms (provided the terms do not designate destruction or agression) and, as a result, may interact more freely than she/he would in a more structured situation. The teacher has an opportunity to observe the child in an unstructured setting. What areas of the room attract the child? Does she/he consistently seek out

special toys? How does she/he respond or react to other children in the room? to adult managers? to unusual noises? to unusual situations? How long does she/he remain with one single item? Is she/he readily distractable by others in the classroom? Can you immediately identify programming priorities from these observations?

(overhead) A formal assessment will provide the teacher with a more systematic checklist of tasks for the pupil, including pre-academic, social, self-help, gross motor, and fine motor skills, and speech-language. These assessments are usually based on developmental milestones already identified in the infant and young child functioning at a chronologically normal level.

This information, while indicating appropriate educational programming, will also provide other information to the classroom personnel. It should indicate what skills the child already has, both directly and indirectly. For instance, if you ask the child to stack blocks and she/he successfully completes the task, you may observe not only how she/he stacks blocks, but also something about the child's grasp-release facility, the pincer grasp, compliance, attention span, and eye contact. This gives you even more information on programming for the child. Assessment often indicates possibly the presence of secondary handicaps to an observant teacher (turns towards one side or favors one side, needs to look at faces in order to respond appropriate voiced commands). It may provide information regarding observed reinforcers, preferred learning modes, and behaviors that it may be necessary to decrease (self-stimulatory, etc.). Results of initial assessment lead directly to the second component of systematic instruction, i.e., developing long-term objectives. Using information from initial assessment, past records, and narrative from parents and others familiar with the child, the teacher is now better able to develop reasonable and realistic long-term objectives for the child.

So, now we surmise that that assessment does in fact serve several purposes:

a. past records about a child may be inaccurate

b. pinpoints goals and objectives

c. legal mandate measurement-objectives

d. places a child appropriately in the curriculum

e. communication

f. establishes good permanent records

g. follows changes in the child-summative assessment (beginning- middle - end of year)

h. secondary handicaps may show up

Best assessment practices

- Do not do on first day
- Do not assess in one day
- Select optimal time and place to assess
- Reinforce (give a raisin)
- Feedback - give good responses back to kid "that's fine"
- Adapt test to handicap
- Be familiar with tools and materials
- Assess more than once a year, at least twice and, hopefully, three times

Do not do on first day

I'm sure I don't need to remind you that any testing done on the first day a child is in a program runs a strong risk of being somewhat invalid. There are generally a variety of things going on that can distort a child's performance. It may be the first time he/she is away from mom, or group and that may be quite upsetting. The surroundings are probably quite different noise level, other children, etc.

Do not assess in one day

If at all possible, try to avoid testing a child in one session. It is better to allow for more than one testing session to really get an optimal test performance from any young child. Young children are not subtle enough to withhold things that may affect the testing situation and so it's really best

to look at performance on several occasions. It's also very beneficial to observe children in different environments, different situations, and with different people to gain greater awareness of their levels of performance.

Select optimal time and place to assess

Certainly we need to have physical plant as comfortable as we possibly can. Examiners need to be aware of things such as when does this child usually nap, is he wet, hungry. Does he have an ear infection--was he up all night?

Reinforce

Try to find something that is reinforcing to this child. Mom may be a good resource. We often find that low functioning kids find primary reinforcers such as food to be very motivational. Be prepared for the child who is orally defensive or not motivated by an obvious means.

Feedback

Give some form of response to the child - social praise "that's fine" - smiles - voice, etc.

Adapt test to handicap

This area requires much consideration if the testing sessions are to be relevant. Examiners need to be well versed regarding the modifications of test procedures required for a specific handicap. We should include culturally different and economically disadvantaged in this group also.

Be familiar with tools and materials

This is not the time to wing it! Nor should it be your first time administering this particular tool. You should be very familiar with the materials and procedures. It's also beneficial to give the same test to normal children so you are aware of typical behavior and have a comparison base.

Assess more than once a year

In order to see growth, it's best to assess at least twice a year.

The Assessment Team

When educational assessment is mentioned, the layman usually thinks of

formal, standardized tests. While tests are quite useful, they are only one part of the assessment process. Classroom observation, actual physical examination and measurement of physical abilities, and long-term information supplied through interviews with persons who know the child are very important. All yield important information not gained from many tests. Additionally, most assessment teams prefer to use a combination of assessment measures as a check and double check to arrive at what would seem to be the best "package" for the population being assessed. Most educators prefer to use several different measures. In our program, it is extremely rare that a professional limits himself to one tool.

The educational assessment should be conducted on a continuing basis by a diagnostic team. No one person has all the skills to perform a comprehensive, diagnostic evaluation, nor can a comprehensive diagnostic evaluation be performed within a certain span of time and then discontinued. As the child progresses, the assessment process must continue to prevent information from becoming outdated.

A diagnostic assessment team might be composed of the following members:

| | |
|---|---|
| Physician: | To assess physical health, physical abilities and/or disabilities, and determine the presence or absence of neurological involvement. |
| Audiologist: | to determine hearing acuity |
| Vision Specialist: | to determine visual acuity or other vision problems |
| Nurse: | The nurse is responsible for the developmental health care needs of pupils in the program. Consultation services within the program as well as referral and coordination with other health care services in the community are part of the nurse's role. The Educational Team is the framework within which all nursing services are provided. The nurse is concerned with all areas of development. Self-help skills, social skills, nutrition, and medication as it relates to classroom management are frequent concerns. |
| Occupational Therapist and/or PT: | to determine presence or lack of sensorimotor integration difficulties and possible perceptual difficulties. The Occupational Therapist provides direct treatment, consultation, and in-service training for staff in the area of motor skills and self-help skills such as feeding where motor |

problems may interfere with pupil progress. All individuals entering the program receive an OT assessment if they have not recently received one at another facility. Using this assessment, the OT works with all of the members of the Team to provide a comprehensive program for the child. The OT administers individual therapy when there is a particular need for the pupil to receive a complicated therapy treatment. In this case, the OT is the only person trained and qualified to administer this treatment. The majority of the Therapist's time is devoted to classroom consultation on specific programs and supervision of those programs carried out in the classroom. Short-term consultation may occur in the areas of proper positioning and handling of the physically handicapped.

Speech Pathologist: to determine receptive/expressive language skills and causes of any difficulties in speech and language not connected with auditory acuity.

Classroom Teacher: to supply information about the child's average daily performance on various tasks in the classroom and his demonstrated skills and abilities in the various areas of concern on a detailed, comprehensive basis because of daily association with children in familiar settings, teachers are able to observe for extended periods of time. By comparing daily performance to test performance, they can often validate or question "formal" test results. The major responsibility should be to collect ongoing assessment data in order to update current educational objectives and educational programming.

Parents: To supply pertinent historical data on the child's development, his current functioning in the home, and important information about the home that may bear directly on the child's difficulties.

Educational Diagnostician or School Psychologist: to estimate the child's mental abilities, social/emotional status, possible processing deficits; to combine the information provided by the other team members into a practical, remedial program.

School Administrators: Although the school administrator does not supply any direct services to the child, she/he does play an important role on the Educational Team. The administrator is the organizer, providing the initial thrust needed to create an Interdisciplinary Educational Team within an educational setting. By giving direction and advice, setting goals, and lending total support, the administrator can give the team the energy to function. At the same time, the administrator must realize that no person on the team "does it all" and that each member has equal status.

During the Team meetings, the administrator sees to it that all pupils have been receiving the necessary educational services. If a handicapped person is in need of services, the administrator sees that . . . those services are either provided by the Educational Team or some outside agency. Special materials or supplies that may be needed for a particular program are either located or ordered. The Administrator also schedules Team meetings and develops needed forms for record keeping. These are very routine tasks performed by other administrators, but are very important to the overall functioning of the Educational Team. Certain forms are needed to comply with state rules and regulations for serving the handicapped. Team meetings have to be scheduled far in advance so all members can plan their own schedules. At meetings where a Team member is absent, the administrator will relay information to the member about the meeting. The administrator directs the meetings in such a way that all information is shared about a particular pupil. Each member of the Educational Team has equal status. Therefore, each member must be given an opportunity to share what she/he knows. The administrator must not be in the way of this exchange of information, but when a decision needs to be made, the administrator must be in a position to make a reasonable one. The administrator can assist the classroom teacher in the development of social behavior programs within the classroom. Many times a teacher has attempted several different interventions to change an inappropriate behavior without success. The administrator can bring additional information to the meeting that may help bring about a behavior change.

Once an Educational Team is functioning, the administrator needs to provide continuous support and reinforcement to the workings of the Team. The whole approach would quickly decay if this support were not given. In this way, the administrator must act as a continual catalyst to keep the Educational Team functioning and on-target.

Under certain conditions, the assessment team may need other specialists such as a Pediatric Neurologist, Psychiatrist, etc. as various problems that require specialists are identified. The team may never meet as a whole, but information from each of the team members is essential for a comprehensive assessment. The continuation of the assessment process on a long-term basis is carried out by the classroom teacher, therapists working with the child, and the Educational Diagnostician or School Psychologist on the case.

In recent years, we have seen the emergence of programs dealing with handicapped infants. One of the major problems in serving this population is providing a valid assessment. Again we encounter problems in finding people who are trained and experienced. Since most training programs do not include training for dealing with young children, it is rare when we find an individual

with a background in early childhood development. There is no substitute for experience with young children. In order to be competent, an examiner must be well versed in testing procedures before attempting to assess a child suspected of having a developmental delay.

In making assumptions about the development of an infant, we often make the assumption that maturation and learning proceed in a sequential and measurable manner, while in reality we know that the rate of development is quite varied with each child. The rate of development of a very young child is more observable and dramatic than that of an older child. For example, one can see significant change in head control of an infant from one week to the next, whereas changes in motor development of a six year old are not as dramatic.

It is critical that those involved in assessing young children be well versed in normal child development in infancy.

In attempting to assess the performance of a very young child, there are many factors involved. We often assume that the child comes complete with all of the normal opportunities for learning, when in reality there may be many hinderances such as emotional overtones, environmental conditions or motor problems, etc., which could distort test behavior.

Some variables in infant behavior include:

1. Temperament which one author divides infants into three personality types:

   a. Average - This is the child who displays a moderate personality. He's moderately active, adaptive, responsive and cheerful. This child is basically easier to deal with.

   b. Passive - This child is somewhat inactive and distant. He is not easily motivated and it is necessary to spend some time familiarizing him with the tasks at hand.

   c. Active - This child is highly mobile and nonadaptive, cries, and generally displays a negative attitude.

In attempting to assess young children, the examiner must be aware of the variable personality types and structure the environment accordingly. For example: the passive child needs time to adjust to the situation; the active child requires a controlled setting. Inexperience may cause an examiner to

erroneously preclude a child's performance due to temperament.

2. Awareness of the child

Examiners need to be concerned with the child's awareness based on some physical needs. How close is it to nap or feeding time? Is he tired from a strenuous activity? Examiners should note during the testing whether they feel the child is able to sustain sufficient alertness and arousal.

Brazleton has developed a scale which divides neonates behavior into 6 categories:

1. deep sleep
2. light
3. drowsy
4. alert
5. active
6. crying

One must be sensitive to the changes in the state of an infant's ability to respond.

3. Physical comfort

Examiners need to be aware of the child's physical comfort during testing situations. Since young children cannot verbalize conditions such as hungry, sleepy and toileting needs, these may affect the child's level of performance. Distractors such as loud noise and changes of test expectations may elicit fear and/or inattentive behavior.

Infants are not able to tell you whether they are comfortable; and, as anyone who is familiar with infants knows, they do not suppress their feeling of discomfort. Parents are a good source of information about the child's level of comfort.

In a school setting, interruptions such as the phone ringing or someone walking into the room may startle or interfere with the child's responses. When working in the home, a dog barking or someone slamming the door may also affect the child's comfort and response.

4. Learning Styles

Children exhibit a variety of learning styles. A child may persevere on

tasks he likes and is comfortable in doing, but may reject tasks that are threatening or unfamiliar. Very often during assessment, a child will reject one or more items. The examiner receives information about a child's preference of activities and style for future program planning even though the test data may be affected.

Examiners who ignore this type of information could conceivably make some errors in judgment regarding a child's capabilities.

5. Unfamiliar Surroundings

Small children often need some amount of time to familiarize themselves with a testing environment and to get acquainted with the examiner. They also seem to need parents close by as a security factor.

Observing how a child reacts to the setting and how long it takes him to become comfortable gives us some information about the child.

Particularly in dealing with infants, children under the age of 8 months usually do not react adversely to new situations. After that time they are quite aware of strangers and unfamiliar surroundings.

6. Structuring the Environment

The examiner should attempt to set up an assessment in an area in which distractors such as telephone calls and movement do not occur. This will enable him to establish and hold attention to the child's potential.

The examiner will note the activities the child enjoys, how he deals with toys, and whether he prefers playing with the examiner or alone.

7. Parental Dependency

We don't know of specific tests which measure emotional development of a young child, but we can make some judgments about the child's emotional maturity by observing how he interacts with his parents and how he deals with a strange environment.

It is generally expected that a young child will use the parent for comforting and will explore the environment with a close eye on the parent for assurance.

It would be significant for an examiner to note the child who hasn't formed the normal relationship with the caregivers in his life.

Techniques of Infant Assessment

As we have mentioned before, the assessment of infants and toddlers is quite different from assessing older children, not die to the difference in tests as much as it is due to the infants' interactive process and social and emotional immaturities. The key to a successful evaluation is the examiner's ability to set up the environment in such a way that the infant feels at ease and comfortable in exhibiting his/her skills.

Infants are especially attuned to the adult's facial features and vocal intonations. The examiner's ability to use eye contact, smiles, and appropriate communication systems with the child is extremely important in establishing rapport.

Since the infant initially has no reason to please the examiner, demands should not be immediately placed on the child. The child should be allowed to take the lead in interaction with the examiner and the environment.

The examiner's role slowly evolves from an unobtrusive stranger, to the offerer of interesting objects, to the active examiner stage. This process may not occur within the first one-hour session. During this process, the examiner must take his cues from the child in establishing the optimum level of rapport. This will be different for each child.

The process of eliciting cooperation from a young child also respects the toddler's need for physical distance, especially in the presence of strangers. A stranger's touch will often elicit a negative response from young children. As a child becomes comfortable, he will begin to approach the examiner to show or offer toys. The experienced clinician waits until the child has made some overtures and then begins to initiate interaction. Gradual tolerance to physical nearness of the examiner begins to occur, and some touching or patting may then be allowed by the child.

Other concerns in establishing rapport with the child include putting the parents at ease with the situation, as a child responds to his/her parents' feelings. Giving parents time to discuss their concerns and treating them as important people in the evaluation process will directly affect the testing atmosphere.

Parents are always anxious about an evaluation process. Recognizing this anxiety and taking time to make positive comments, reading their concerns, and explaining the assessment process will help put the parents at ease.

The Process

The overall assessment process usually begins with a parent interview which gives the examiner a picture of the child's development, the parent-child relationship, the parent-parent relationship, and how the parent feels about the child's handicap.

The interviewer should include:

1. The parents' concerns: Determining the parents' reason for seeking an evaluation is an extremely important piece of information. Their perception of the child's problems and their acceptance or denial help the evaluator identify assessment and intervention strategies.

2. The Developmental Sequence

Milestones in the child's motor language and social development will indicate to the evaluator where to start in the assessment process.

3. Medical History

Information about illnesses, hospitalization and medications are crucial for several reasons. A serious illness such as meningitis may imply some complication such as central nervous system involvement. Hospitalization may affect the child's emotional development and medications may have an affect on the child's responsiveness. The following factors are also significant:

1. Feeding and sleeping habits

2. Child's attachment and separation problems

3. Parental and family issues

4. The parents' feelings about the delayed child

5. Any behavior management problems

Transition to Actual Assessment

During the interview process, the child has had the opportunity to interact with selected toys made available to the child. At this stage, the evaluator may begin to present materials trying to engage the child directly. Simple testing materials which will likely result in success are presented first and more difficult tasks should be reserved until the child seems comfortable and ready to work. Being undemanding and working playfully and gradually into a structured situation will help motivate the child.

Determining when to change is a difficult decision. The examiner should present a new item to the child and establish his interest before removing the other item to avoid frustration. As tasks become more difficult and a child begins to fail, the examiner should reassure the parents that success was not expected. The examiner should be sensitive to the child's frustration level and terminate the procedure. The parents will appreciate some honest feedback even though exact results may not be readily available.

In assessing infants, it is not unusual to have items that cannot be scored for a variety of reasons and another assessment time required.

Upon completion of the assessment, a meeting should be held as soon as possible to inform the parents of the results of the assessment evaluation. At this time, suggestions and recommendations for intervention strategies should occur. Not every child will need a specialized program; however, input regarding activities a parent can do in general to enhance development can be made. This is also a good time to praise parents for the positive parenting techniques which they have employed.

Very briefly we have attempted to present some principles for assessing and

evaluating young children. The evaluation process is only the first step and is meaningless without followup and intervention.

| | Sequenced Dev. Level | Chronological | Age | Screening | Assessment | Assessment and Program | Cross-Reference | Behavioral Objectives | Criteria for Exit | Visual Performance Chart | Record System | Training Activities | Materials (puppets, etc.) | Specific Disability | Gross Motor | Fine Motor | Language | Expressive/ Receptive Lang. | Self-Help | Social-Emotional | Cognitive | Perception | Parent Involvement | Parent Training | Parent Objectives & Exit Criteria | Home Program | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PEABODY KITS | | | | | | | | | | | | X | X | | | | X | | | X | X | | | | | | |
| CAMS | X | 0-6 NS | | | X | | X | X | X | | X | | slide tape | | Motor | X | X | X | X | | | X | X | | | | |
| DENVER | X | 0-6 yr. | | X | | | | | | | X | | | | X | X & the | X | | | Soc/ Personal | | | | | | | |
| CIP | | | | X | | | | | | X | X | | X | | X | X | | Exp. | | | X | Ad V | | | | | |
| LAP | X | 1-7 | 4 mth. | | X | ? | X | X | X | X | X | Book | X | | X | X | X | X | X | X | | | Can be adapted | | | | |
| (Filmstrip) CHAPEL HILL | | | | | | | | X | | | | X | | | | | X | | | | | | X | X | X | | |
| PERFORMANCE OBJECTIVES & CURRICULUM | X | 1-6 yrs. | | | X | X | X | X | X | X | X | X | | | X | X | X | | X | social | X | Med. Problem | | | | | |
| LEARNING STAIRCASE | X | 2-7 yrs. | | | X | X | X | X | | X | X | X | | | Covers all of the above and more | | | | | | | X | X | | | | |
| VINELAND | X | Birth | 18 | ? | | | | | | | | | | | Locomo-tion | | X | | X | X | | | | | | | |
| TARC | | | X | X | | | | | | X | | | | SEU/ Hewett | Motor | | X | | X | social | | | X | | | | |
| KOONTZ | X | 0-48 mth. | | | X | X | X | | | X | X | X | | | X | X | X | X | | social | | | | | | | |
| UPAS | X | 0-9 yr | | | X | | X | X | X | | X | | | | X | | X | X | X | social | X | | | | | | |
| SEED | X | 0-48 mo | | | X | | X | | | | X | X | | | X | X | X | | X | X | | | X | X | X | X | |
| RHISE | | | | | X | | | | | X | X | X | | | X | X | X | X | | X | | | X | X | X | | |
| STEP | | | | | | | | | | | X | X | | | | | | | | | | | | X | X | | |

| | Sequenced Dev. Level | Chronological Age | Screening | Assessment | Assessment and Program | Cross-Reference | Behavioral Objectives | Criteria for Exit | Visual Performance Chart | Record System | Training Activities | Materials (Puppets, etc.) | Specific Disability | Gross Motor | Fine Motor | Language | Expressive/ Receptive Lang. | Self-Help | Social-Emotional | Cognitive | Perception | Parent Involvement | Parent Training | Parent Objectives & Exit Criteria | Home Program | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TEACHING RESEARCH CO. | | Pre-school | | | | X | All Task Analyzed | X | | | | | Mod/ Source | X | X | X | X | | X | | | | Home Teaching Parent Program | | | | |
| (Readings) PORTAGE PARENT PROG. | | 0-6 yrs. | | | | | | | | | X | X | | | Motor | X | | X | social | X | | | | | | | |
| PORTAGE CURRICULUM | X | 0-6 yrs. | | X | X | X | | | | | X | X | | | Motor | X | | X | social | X | | | X | X | X | | |
| MANAGING BEHAVIOR | | Pre-$ &Elem. | | | | | X | X | X | | X | Film-Strip & Logs | | | X | X | X | | | X | | | | | | | |
| DASI | X | 2½ yr.+ | X+ | | | | | | | | | | | Sev/ Pro/ Deaf- Blind | Motor | | | | | | X | | | | | | |
| CALLIER-AZUSA | X | | | X | | | | | | | | | | | | | | | | | | | Assess Home Environment -- No Program | | | | |
| HOME | | 0-6 yrs. | | | | | | | | | | | | | | | | | | | | | | | | | |

# ADMINISTRATIVE ISSUES IN

# DEVELOPING PROGRAMS FOR PRE-SCHOOL CHILDREN

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The Gallatin-Madison Co. Special Education Cooperative serves 18 schools in southwestern Montana with some districts as far away from the Belgrade Center as 100 miles. Because of the distances that have to be traveled, we have divided our pre-school program into two conponents. The first component is a center-based pre-school program which runs 4 half days per week (Monday, Tuesday, Thursday and Friday). The fifth day is used for home training, consultation, and evaluation for those children who cannot utilize the center program on a daily basis.

## CHILD FIND

Introduction - For the purposes of the present discussion, Child Find is being defined as the process of identifying children with potentially handicapping conditions as early as possible. The key issue in this discussion is to share our approach to Child Find from the beginning of the Child Find screening process through evaluations and some placement possibilities. To do this, it is essential to mention the following principles to which we try to adhere in the Child Find Process in the schools:

1. Throughout the Child Find process there is an effort to maximize the use of existing school professionals and thereby reduce the need to hire personnel, i.e., speech and language clinicians, kindergarten teacher, resource teachers, psychologists, audiologists, nursing staff.

2. We have found it extremely useful to provide staff training prior to the beginning of Child Find in order to help the professionals coordinate their effort and work together more effectively. In addition, it gives us an opportunity to provide any special skills training that might be necessary, e.g., vision testing.

3. We always begin a Child Find process with a prescreening process. Throughout this prescreening process, there is an effort to keep

in mind the age of a child in order to maintain a realistic picture of any child's eligibility for an access to certain programs, e.g., two year olds can be evaluated but at this point no service will be provided until they turn three years of age because of Cooperative policy.

4. Child Find is only the initial prescreening and there must be a provision for referral of children for further evaluations.

5. Post screening evaluations always begin with a simplest approach and work towards more complex evaluations depending on the needs of the child. This point will be discussed further in the evaluation section.

6. We strongly advocate data keeping as being essential beginning in the prescreening level of child find in order to document from the beginning the need of any child for special placement necessary.

The remainder of the discussion centers around the details of the child find process.

Age Ranges - Age ranges for Child Find are essentially from 0 to a pre-five year old level. This means simply that those children who turn five in time to be eligible for kindergarten in any given year prior to September 10th, are not included in the Child Find process because they are involved in a kindergarten screening process in this area of Montana. Essentially, the age ranges for Child Find can be divided into the following three groups: 0-3 years of age; 3-4 years of age; 4-5 (pre-kindergarten). Depending on the approach used in the Child Find Process, specific levels of testing can be worked out for each of these three groups. In our approach to Child Find, the initial prescreening process is the same for all children and is then follow-up if necessary by evaluations which vary depending on the age and needs of the child.

Pre-Screening - The notion of prescreening is central to the initial contact aspect of our Child Find process. This simply means that we divide Child Find first into a pre-evaluation or prescreening segment which includes the following:

1. An audiological evaluation which consists of both pure tone screening and impedance.

2. A parent interview during which time a prescreening form is filled out for each child. It is essential that the Preschool Screening Form be filled out completely and t at there is time with each parent to discuss a variety of potential y handicapping conditions and problems that might be identified in this interview. (See attached Pre-School Screen-

ing Form)

Our philosophy is that it is much more cost effective to keep the prescreening and initial contact phase of Child Find very simple and still get adequate information to make decisions about further evaluation, referral or any other necessary follow-ups. A critical component in this process is that in order to fill out the Pre-school Screening Form, a certain amount of clinical judgement is required. This means that the form must be filled out by a professional and not an aide or parental assistant. We want to emphasize that this pre-school screening form is filled out on every child and is used only at the initial contact stage. If any questions arise regarding a child while this form is being filled out, there is a provision for referral and further evaluation if necessary.

To summararize, our experience suggests that an effective approach to the initial aspect of Child Find is to make a process very simple and streamline. Given this position, we have found that hearing screening and an initial parent interview using the structured Pre-School Screening Form is most effective in identifying children with potentially handicapping conditions who will need further evaluation and referral. We have also found that it is essential to carry out this Child Find process in this area throughout the year and not as a one-time activity either in the beginning of the year or at the end of the year. For this reason, Child Find is carried out by us at the same time as the regularly scheduled audiological screening throughout the year. Following this prescreening process, all audiological reports and pre-school screening forms are reviewed and when necessary, children are referred for evaluation. Vision testing has been discussed in this segment, but it can also be carried out during this prescreening process if necessary. However, our experience is that attempting to do a vision screening on a child that is less than four is not very effective in the school setting.

Evaluation - If, based on the prescreening parent interview and child observation data, an evaluation of a child is deemed necessary, the first consideration is to

identify the potential handicapping condition that child may have. The potential handicapping condition of the child is established in order to decide who does the evaluation and how complex an evaluation may be necessary in the initial effort. In addition, this is also a time when physician referrals are usually made.

In our experience, we have found that is is most often the case with the zero to five year old group that evaluations begin with speech/language and communication behavior in general. We have found that speech and language problems are evident in nearly all of the children referred for evaluation in this age range. By beginning with the speech and language evaluation, it allows us to assess an area which is both inclusive of other areas and also academically necessary for the child to function in school. It should be pointed out, however, that this does not mean that other areas of potentially handicapping conditions are ignored. On the contrary, the issue is simply that we usually start with speech and language as the handicapping condition and the basis for the initial evaluation because of its centrallity to the child's welfare. Following the initial effort by the speech and language clinicians, appropriate referrals are always made for futher evaluation from the psychologists, resource teachers, and any other appropriate staff member. In this way, a child is made eligible for services by being assigned a handicapping condition of speech and language problems and then other areas of concern can be followed-up on without any serious delay and made part of the ongoing process of parent communication.

The next most important issue to establishing a handicapping condition in the evaluation process is the need for a clear initial and continuing behavioral description of the child in some depth. We have found it essential to establish base-line levels of speech/ language and preacademic function for these children and to be able to document the child's progress beginning with the initial evalutions. The establishment of a base-line level of function, behavioral description and a notation of continued progress has time and again proved to be essential for establishing a data base so that if necessary, the child can be assigned to

a more definitive handicapping condition in later years.

To summarize, we find that it is essential to begin the evaluation process by identifying a potential handicapping condition and making whatever special referrals are necessary. Additionally, a useful approach is to begin with speech and language as a handicapping condition and have the inital evaluation concern itself with the child's level of speech and language functioning. Following this, further evaluations in other handicapping areas can take place.

Further Evaluations - Following the evaluation, it may be necessary for a more detailed assessment to be provided and cannot be provided within the school system. If this is the case, there is a provision for referrals to be made to special or university clinics for further evaluations. Our position is that this type of referral should occur only after the school has exhausted all of its resources. We do subscribe to the position, however, that other agency involvement can be very useful. This is also the time when specialized medical services may also become necessary.

## FUNDING

Funding for our pre-school program has been carried out by utilizing a Pre-School Incentive Grant under EGA Part-B. Because we use federal dollars as our basic source of revenue to operate, the impact of federal cut backs will have a drastic effect on our program. We are in the process of considering a number of changes in program models which would provide less expensive alternatives than a center program. This will be discussed further under program considerations. Because of questionable funding, the high cost obligations such as staff salaries, benefits and extensive travel will have to be reviewed extremely close in order to justify the expenditure.

## PROGRAM CONSIDERATIONS

Special Education Pre-School Programs - When there are sufficient numbers (5-10) of pre-school children, a center based special education pre-school program that provides daily ½-day service probably is the best type of intervention for pre-

chool children who have fairly severe handicaps. We have found that some costs have been reduced by using high school students in place of hired aides. The high school students generate elective credit and usually come during their study hall period.

Regular Pre-School Programs - Because most of our pre-school children enter the program with speech and language impairments, we usually want those children in environments which provide good speech models as well as structured experience opportunties. Day-care centers, pre-school programs, etc., can offer enough positive experiences for the child to make that placement highly desirable. Payment is usually contracted by the special education cooperative and written program objectives are made part of the contract. Usually the speech clinician provides consultation to the pre-school on program issues and will provide direct therapy if indicated by the Individual Education Plan (IEP).

Administratively, this has some benefits. If you have great fluctuation in numbers of children or minimal numbers, the district does not have an ongoing commitment to personnel but can respond on a child-by-child basis. The per child cost is usually less expensive than running your own center-based program unless you have a stable number of children and enough children. Also, if you don't have a child in service, the cost is nothing. Usually, there is a service like this in most towns so extensive travel is minimized. We also like the advantage of placing children in normal situations during those early years rather than assume a more restrictive environment. If a child is more severe, some special arrangements may have to be made for accomodation in this type of setting.

Home Training - This has proven to be a very successful intervention strategy particulary in a rural setting in other places. Of major concern now is the high cost of travel and time spent on the road to our rural areas. In order to resolve these kinds of problems, we are looking at having our local district special education teachers providing home training to the parents of handicapped children. We would pay an adult education rate, usually $7.50 per hour for that

teacher to go into the home after school hours to provide instruction. This would be a relatively economical program and we would have a trained professional doing the program. We would have to do some inservice training for the staff involved but that would be a minor issue to resolve.

Control to this whole program is our philosophical approach that we do not have to control any program or have final say in how it goes. We promote the involvement of other agencies and their assuming any portion of the responsibility. We will facilitate any other relationship we can with our only requirement that we be kept informed of the child's status. In this way, we have a shared responsibility as well as shared cost. Most important, the children involved get a reasonable program. Agencies and programs that we work with include: Family Outreach, Department of Welfare, Department of Health, Montana State University Child Development Center, Easter Seal, portions of regular district kindergarten programs, resource rooms, Private pre-schools, Day-care Centers, and even baby sitters. Interagency coordination is essential so that children are not lost between agencies.

Special Consultants - Because of the small number of children that we have in program and the complexity of problems these children have, we rely on special consultants to assist us with evaluations and program strategies. Project Sunrise, Montana Center for Handicapped Children, Shodair Genetics and Birth Defects Clinic, Western Montana Comprehensive Developmental Center, and Montana School for the Deaf and Blind are all excellent sources for assistance.

## RULES AND REGULATIONS

In order to develop creative, flexible programs, the foundation must be set with rules and regulations at the state level in the very near future. At the present time, the regulations which were written for school age children are used as a basis to establish program and many times are extremely inappropriate when applied to pre-school programs.

Specific issues which must be addressed in regulations include:

Teacher Certification - Presently teaching certificates are required by professional staff to work in pre-school program which means that a teacher must hold an elementary certificate. This training does not address to all the competencies needed for a teacher of handicapped pre-school children. Special consideration must be given to individuals who have all the compentencies needed but have degrees in Early Childhood Education, Educational Psychology or Speech Therapy.

Handicapping Categories - Because it is so difficult to accurately diagnose some handicapping conditions (e.g., L.D., E.D., M.R.), at an early age, special consideration should be given to using a "high risk" category as a basis to enroll some children into program. This would give schools a legitimate basis to work with children while they compile data to substantiate a bonafide handicap or let program intervention impact the child's development so the child will not need special education services when they are old enough to attend school. This would follow the D. D. model of "High Risk".

Purchase of Service - The regulations drafted must look at not only intervention utilizing special education services but other services which would provide learning experiences appropriate for the child. Regular pre-schools, day-care centers, etc.; though designed for normal children, provide excellent opportunities to help handicapped children. We see this as a special education responsibility to purchase these services, because without them the child will not make the gains needed.

In summary, we could say that most administrative issues related to pre-school programs can be dealt with if one approaches the issues in a creative and flexible way. Rigidity, inflated egos, territorial rights, etc., all contribute to problem plagued programs which in turn hurt service to children. If you sell your program to your clients and community in a positive way, you will get the support you need to make the program go and have the dollars to do it.

GALLATIN-MADISON CO. SPECIAL EDUCATION COOPERATIVE
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PRE-SCHOOL SCREENING

Date: _____ Resident School District _____

Child's Name: _____ Sex_____ Birthdate _____

Parent's Name: _____ Phone _____

Address: _____

Person Completing Form:_____ Position_____

Why did you bring your child into be screened? _____

_____

What are your specific concerns?

_____ Developmental Delays - Specify Area(s) _____

_____ Attention Span _____ Perceptual

_____ Vision _____ Motor

_____ Hearing _____ Speech

_____ Behavior _____ Language

_____ Emotional _____ Social

_____ Physical Handicapped _____ Other

Additional information explaining the above reasons and/or situations which make you feel that an evaluation is needed: _____

_____

Has the Child ever been referred and/or evaluated before? _____Yes _____No

BY WHOM? _____ DATE _____

Health Information (good, fair, poor):

General Health Condition _____ Vision_____ Hearing _____

Nutrition _____ Pregnancy _____

Identify other Health Problems: _____

What special programs have been tried or are now in progress? _____

_____

Have the child's problems been discussed with the parent(s)? _____ Yes _____No

BY WHOM _____ DATE _____

Briefly describe the outcome of the parent conference _____

_____

What service do you feel this child needs? _____

= = = =

# PROJECT FAMILY LINK I

## A Home-based Intervention Program for Young Handicapped Children and Their Families

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Project Family Link I is a rural home-based intervention program for handicapped children ages birth through four years. The project, funded by the Bureau of Education for the Handicapped, United States Office of Education, is designed to promote emotional, cognitive, and physical growth and development in young handicapped children through a home-based model. This model utilizes parents as teachers and emphasizes adaptive changes in the family of the handicapped child. Family Link I is administered by the Special Projects Division of Texas Tech University, Lubbock, Texas, under the direction of Dr. Mary Tom Riley.

Project Family Link I serves young handicapped children and their families who reside in a ten-county region surrounding Lubbock, Texas (See Figure I). These ten counties cover a total of 9091 square miles and have an estimated population of 131,859, making the area served a predominantly rural one. The primary economy of the region is agricultural and many of the enrolled families are engaged in some aspect of farming. Because of this emphasis on farming as a livelihood, the population of this region tends to be somewhat migrant, either moving from one location to another within the service area or moving out of the area entirely in an effort to follow the seasonal agricultural needs.

As might be expected with a predominantly rural, somewhat migrant population, most of the families served by the project fall in the lower socio-economic levels. Many are single parent families, many are on welfare or other supplemental income sources, and over half are bilingual with Spanish the more comfortable language for communication.

FIGURE 1

AREA SERVED BY
PROJECT FAMILY LINK I

180

## PROGRAM MODEL

Project Family Link I utilizes three components in delivering services to young handicapped children. These components are Home-based Teaching, Family Involvement, and Linkage of Services.

### HOME-BASED TEACHING

Project Family Link is based on the Portage Project model (Portage, 1976). This model, originally developed for use in rural home based programs for the handicapped in Wisconsin, has been adapted for use in West Texas and stresses parental involvement and utilization of paraprofessionals as home-based teachers.

Once a child is referred to the program, a home visit is made to explain the program to the parents and have them sign various release forms. The child is assessed with formal measures such as the Bayley Scales of Infant Development (Bayley, 1969) and the with the Portage Checklist and Alpern-Boll Developmental Profile (Alpern and Boll, 1972). The latter two measures are administered by the home-based teacher.

Following assessment, an Individualized Education Program (IEP) is developed for the child by a committee that includes, minimally, the parent, home-based teacher, and project coordinator. If the child is enrolled in another program or is receiving additional services, representatives of these agencies participate as well. After the IEP is written, home visits begin.

The home-based teacher assigned to each enrolled family visits the home once a week for a period of one and one-half hours. During this time, the teacher instructs the parent in what to teach, how to teach, what to reinforce, and how to observe and record the child's behavior. Parents are required to keep a record of the child's daily performance, which is used to evaluate progress and plan subsequent activities. This process is based on the Portage model and involves four steps:

1. Three behavioral goals are selected for the child each week;

2. Baseline data on the new tasks is recorded by the home-based teacher each week and the parent is shown how to implement the new activities;

3. The parent implements the teaching process during the week;

4. Post assessment data is recorded by the home-based teacher one week later to determine if the new tasks have been learned. At this point, the teacher may demonstrate new activities or may determine that the previous ones should be continued.

The tasks implemented each week are designed to facilitate the child's development in language, self-help, social, motor, and cognitive skills.

The model for home-based intervention utilizing the concept of "parent as teacher" is logical in view of the geographic situation and the lack of appropriate intervention programs for young handicapped children in fairly isolated areas. This same rationale is the basis for utilizing paraprofessionals as home-based teachers in service delivery. The use of paraprofessionals is a highly cost-effective strategy in delivering intervention services in rural areas, where great distances and small numbers of families prohibit the use of degreed teachers. In addition to the cost factor, another positive aspect of utilizing paraprofessionals is the quality of interaction with parents. Home-based teachers in Family Link have developed a trusting relationship with families, as evidenced by parent's attitudes toward home visits, willingness to confide in teachers, and desire to have teachers present during contacts with other agencies. This rapport enables the teacher to stimulate parent-child interaction, so that parents become more effective with their children.

FAMILY INVOLVEMENT

Involvement of families in the child's program is a critical aspect of Project Family Link. The nature of the home-based program demands a fairly high degree of parental involvement in the child's program, where parents are primarily responsible for carrying out planned activities with their child. Further family involvement is encouraged through Family Albums, participation in Family Day programs, and through linkage activities.

Each family enrolled in Project Family Link is furnished with a Family Album

scrapbook which becomes the family's permanent and ongoing record of their experiences in the project. The album contains photographs and momentos of a family's experiences in Project Family Link I, and is divided into four sections: Family History, Family Visits, Family Fun, and Family Friends. Each home-based teacher is provided with a camera for taking pictures during home visits, Family Days, and other activities, to be included in the Family Albums.

The Family Days program is a vital part of Project Family Link I. At selected times during the year, families are brought together to meet and interact with each other and to engage in special activites. Parents are provided with training programs that deal with topics of interest and concern to them, while children engage in educational programs designed by staff who are trained in the needs of special children. Families are transported to the project site for a day of activities, lunch, and opportunities to visit with other families. Family Days provide a source of contact with other project families and with activities outside the home.

Families are encouraged to become involved in the handicapped child's program and to seek appropriate services for the child. One section of the Family Album includes documentation of linkages to service agencies involved with the child. By providing a family with a record of agencies contacted in their behalf, the family has access to the agencies and is kept aware of services they have received. Even after contact with Family Link I has ended, the family can continue to maintain contact with agencies they have been associated with during Family Link I involvement.

LINGAGE OF SERVICES

Because many Link I families live in fairly rural areas and are not familiar with methods of obtaining needed services for themselves and their handicapped children, Family Link I considers linkage one of its priorities for enrolled families. Family Link I has developed a process for determining what services a family needs, how the services are to be delivered and by whom, and documenting or recording the services for both staff and family use. This process helps identify

gaps in service for a particular family and for families who are not receiving services to which they are entitled. It also facilitates communication and coordination among agencies.

Project Family Link maintains contact with support service professionals in the communities served by the project in an effort to coordinate specialized health, social, medical, and handicap services needed and received by enrolled families. It coordinates services between public schools, Child Find representatives, and area community service agencies, and helps provide a transition for the child into public school programs or other preschool settings such as Project Head Start. By acting as a liaison agency on behalf of the family, Project Family Link I aids the family in their contacts with health and social service agencies and agencies providing services for handicapped children.

Linkage services for families are documented by project staff, and may be either agency contacts or staff services to families. Agency contacts are documented when a staff member contacts or is contacted by an agency on behalf of a family. Staff services to families are documented when staff assist families in securing services, such as providing transportation to a doctor's appointment. These records help document the type and frequency of assistance to families. Examples of linkage activities are transporting families to agency appointments, arranging diagnosis and evaluation for enrolled children, helping families secure funding for needed services, and contacting agencies to secure equipment.

## DISSEMINATION

Project Family Link I is involved in dissemination of information concerning the model and the concept of early intervention for young handicapped children. Dissemination efforts focus on two products: a booklet entitled Family Link and the Family Album (1979) and a 16 mm film entitled The Fortunate Few (1979).

The Family Link booklet describes the home-based project and the Family Albums. It provides a brief overview of the project and services offered to families. More in-depth information may be obtained by writing the project office.

The film, The Fortunate Few, was developed by Dr. Mary Tom Riley, Associate Professor and Special Projects Director, and Dr. Alice Hayden, Professor Emeritus, University of Washington. It describes "the fortunate few" as those young handicapped children who are receiving intervention services at an early age, and emphasizes the necessity for such intervention for all young handicapped children. It is available for rental or purchase through Calvin Communications, Inc.

## CONCLUSION

The Family Link model for home-based intervention for young handicapped children has proven to be an effective means of service delivery in a rural area. The use of paraprofessionals as home-based teachers, the emphasis on family involvement with the "parent as teacher," and the concept of linkage of families to services have enabled Project Family Link I to provide a comprehensive service delivery program for handicapped children and their families in a rural area of West Texas.

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# TEACHING SELF-CONTROL TO YOUNG HANDICAPPED CHILDREN

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The ability to regulate or control one's own behavior is perhaps one of the most adaptive skills an individual can master. The importance given to self-control is indicated by the prominent role it plays in developmental assessment. It is a major subsection, for example, in the AAMD Adaptive Behavior Scales. Teaching self-control to children seems to be the best way to overcome two major problems often found with programs which rely on external control only. These are maintenance following cessation of the program and generalization to other settings and time.

Our training program has shown that young handicapped children can be taught to accurately observe and evaluate their own behavior. Learning self-control resulted in significant decreases in disruptive behavior which had seriously interfered with their educational experiences in the classroom. Further, the change in behavior was observed to generalize to a time when the program was not in effect and to sutstitute teachers.

The initial program involved 12 children ages 5 to 11. The children's handicapping conditions included Down's Syndrome, PKU, autism, childhood schizophrenia, mental retardation of unknown etiology and brain damage. Their performance on standardized IQ tests indicated a range from 33 to 64 with a mean of 47.

The program involved a total of 12 phases over a 6-month period (116 school days). Although the children's behavior was monitored during both the morning and afternoon sessions, the program was only introduced during the morning sessions. Behavioral observation during the afternoon sessions thus served as one measure of generalization. Two other indices of generalization were obtained during an "Off Day" once each week when the program was not in effect and during

days when the regular teacher was absent and a substitute teacher taught the class.

The rationale of the program was to first familiarize the children with the rating of their behavior and then teach accurate self-rating through feedback, extrinsic reinforcement and matching of their self-ratings with those of their teacher. Finally, we hoped to fade out these external supports. The 12 phases of the program were as follows: baseline, systematic feedback, token reinforcement, matching, fading I, fading II, fading III, fading IV, self-evaluation, inflation, points only, and baseline II.

BASELINE (8 days)

The teacher announced to the class that the observers "are learning to be teachers and will be visiting our class. Their teachers won't let them talk to so us so I can't let you talk to them either." Observers were instructed not to interact with the children or teacher. The children's behavior was monitored every school day morning and during four afternoon sessions but no program was introduced.

SYSTEMATIC FEEDBACK (17 days)

During this phase the teacher set a timer for five consecutive 10-minute periods during the morning session. At the end of each 10-minute period, when the timer sounded, the teacher would tell each child, as she went around the room, whether he/she had been "good," okay," or "not good" during the preceding period. The teacher based her evaluation on whether, in her opinion, a child had emitted no disruptive behavior (good), one disruptive behavior (okay), or two or more disruptive behaviors (not good). While this system was suggested as a general rule, the teacher set her own criteria. She individually informed each child of the reasons for his/her rating. Behavioral observation alone continued during the afternoon session. The teacher continued to engage in regular educational activities with the children during all sessions.

TOKEN REINFORCEMENT (12 days)

Once the concept of "good," "okay," or "not good" had been established, a

token program was introduced during the morning session. At the end of each of the five 10-minute periods, the children were individually awarded two points, one point, or no points, corresponding to a rating of "good," "okay," or "not good" for that period. Each child would earn, therefore, a maximum of 10 points during the morning session. Each child's points were displayed on a "token calculator" which had movable slides with 0 through 10 points (representing 0 through 10 tokens) indicated on them beside the name of each of the children. As a particular child earned points the slide beside his name was advanced accordingly. Immediately following the end of the fifth 10-minute period each day, an exchange period was held during which the children exchanged the points they had earned during the preceding session for edibles and/or special activities such as arts and crafts, being teacher's helper, etc.

Due to a school schedule change during this phase, which did not allow enough time for the exchange period, the program was not in operation on Wednesdays. Behavioral observation continued, however, and provided an additional measure of generalization (i.e., "Off Days").

MATCHING

The Matching phase was introduced by the teacher telling the class that they would be rating themselves and trying to match her rating following each of the 10-minute periods. Successful matching resulted in the delivery of the number of points agreed upon by the teacher and child and a bonus M & M in addition. Failure to match resulted in no M & M and a point penalty.

FADING PHASE (28 days total)

After the class had demonstrated proficiency in matching the teacher's ratings, a series of fading phases were introduced to gradually eliminate external evaluation. The number of children who "got to match" was systematically reduced. Those who were not randomly selected by having their names drawn, were given the number of points they awarded themselves (Drabman et al., 1973). The previous described matching contingencies remained in effect for those who were selected to match. Matching was highly praised and the importance of honesty stressed.

The teacher continued to rate the children who were not required to match but feedback was not given to them. Points were exchangeable as before.

FADING I (8 days)

The names of six children were drawn from a hat as those who "got to match."

FADING II (7 days)

Four children were selected to match during this phase.

FADING III (5 days)

The number of children selected to match was reduced to two.

FADING IV (8 days)

Only one child was picked to match during this final fading phase.

SELF-EVALUATION (13 days)

All the children rated their own behavior after each 10-minute period and received the number of points they awarded themselves. The teacher continued her own ratings but no one was required to match, and the children were not informed of her ratings. As before, the accumulated points were exchangeable for back-up reinforcers.

INFLATION (4 days)

To help fade out the reinforcers, an "inflation phase" was introduced by the teacher as "like the prices going up in a real store." During this phase the children continued to self-rate, but the point cost of the back-up reinforcers was doubled. The teacher continued to unobtrusively rate the children, but feedback was not given.

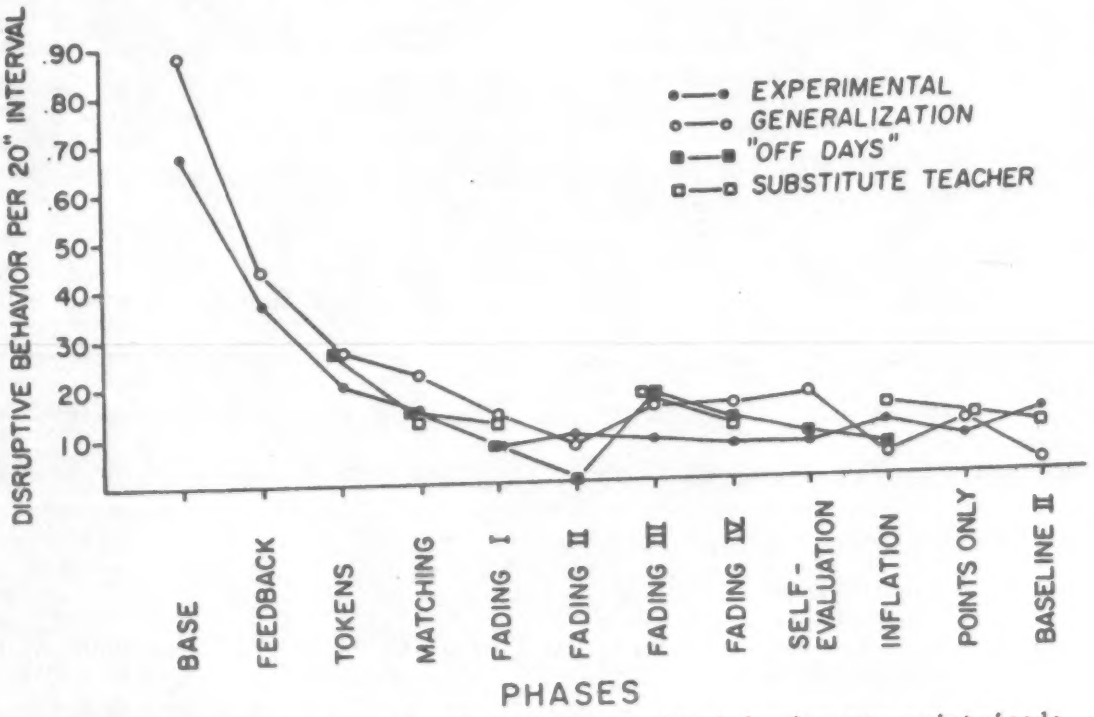
POINTS ONLY (5 days)

Back-up reinforcers were eliminated during this phase, but the children continued to rate themselves after each 10-minute period. The teacher continued to rate the children without giving feedback.

BASELINE II (5 days)

The program was completely withdrawn during this final phase with a return to baseline conditions. Additional follow-up could not be obtained due to the end of the school term and reassignment of the children.

The percent agreement between the children's self-ratings and their teacher's rating of their behavior matched 98 percent of the time at the end of the program. Disruptive behavior, which included noncompliance, inappropriate noise and vocalizations, out of seat and off-task behaviors was monitored thoughout the training. As shown in the figure, disruptive behavior incompatible with learning decreased consistently over the course of the program.




Equally important, the reduction in disruptive behavior was maintained; (1) when the program was not in effect at another time of the school day, (2) during once a week "off-days," and (3) when the regular teacher was absent and a substitute teacher taught the class.

The results of the program are exciting because they show that disruptive developmentally disabled children can learn to accurately rate and regulate their own bahavior.

# FACILITATOR: AN ALTERNATIVE SERVICE MODEL

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When the new state and federal regulations outlined the options for a continuum of services in Special Education, it became apparent that a new component was needed in this continuum. The role of a Special Education Facilitator became the new key element in the network of program options as it could provide the coordination of special and regular education within an assigned building. It also would assure that all building level resources were being optimally utilized before special building placement could be requested.

Due to the new legal mandate requiring maximum utilization of the regular class setting, every effort must be expended to improve the capabilities of regular classroom teachers to successfully provide for a diversity of students' needs. Therefore, a major role for the Facilitator is to provide the following kinds of assistance to the regular class teacher: clarify students' special needs; help locate and/or develop appropriate materials; help to instruct and give support to both the teacher and the special needs students.

The Facilitator becomes the first referral point in the special education spectrum for both learning and social adjustment problems. In a case where both the referring staff member and the Facilitator feel that direct instructional services from special education are indicated, the Facilitator provides process leadership to the multi-disciplinary Child Study-Due Process Team. This leadership includes such things as arranging for assessment, program planning, and assuring that all legal procedural safeguards are followed.

After the student has received direct services from a special education staff member, the Facilitator can assist in the transistion back to regular classes as the student becomes ready for a less restrictive program.

When done conscientiously, the role of Facilitator takes energy, patience, considerable creativity and competence in many areas. The Facilitator should be quietly self-assured and must find satisfaction in undertaking difficult tasks, yet maintain realistic expectations and above all, not be easily discouraged. The Facilitator acts as a catalyst by: 1) bringing others to full potential; 2) being empathetic; 3) being able to start with teachers at their present level of expertise; 4) consistently being supportive without losing the sense of mission; 5) responding to a change in process without a change in goals. The Facilitator must also develop a broad repetoire of instructional strategies and techniques, intervention models, and ideas. Essential to this role is a regular review of literature, professional growth seminars, college classes, etc. Therefore, the Facilitator must be capable of developing a broad range of diagnostic and prescriptive skills thus benefiting from the continually expanding technology in the field.

The Facilitator's training should be individualized to the specific needs of each Facilitator. It is recognized that each Facilitator comes with a different background and different competencies. Therefore, areas of training emphasis will vary for each. However, basic in-service curriculum should include the following:

1. Psychological and sociological theory and practice in understanding human behavior, both child and adult.

2. Training and knowledge in a wide range of instructional techniques for cognitive learning.

3. Training and knowledge in a wide range of instructional techniques for affective learning.

4. Training and knowledge consultation techniques specifically as it pertains to Level II services and to facilitation of multi-disciplinary teaming.

5. Training and knowledge in assessment, evaluations, diagnosis and planning with emphasis on learning environment assessment, evaluation and diagnosis of children through informal (non-standardized) instructional/diagnostic processes, and specific individualized educational plans.

6. Experimental training in communication, self-evaluation, personal growth, and stress reduction and/or toleration techniques.

In general, the Facilitator role has four task areas: 1) participating in the duties involving services to students in the regular classes; 2) helping identify and plan for handicapped students not in school; 3) controlling the Child Study-Due Process procedures; 4) participating in the duties involved in returning identified special needs students to the regular classes. In the Anoka-Hennepin School District, the Facilitator job description assumed seven basic task areas:

1. Initial student review reference point
2. Coordination of assessment process
3. Coordination and scheduling of building child student teams
4. Facilitator of communication process
5. Instructional programming modifications
6. Specifically defined teaching responsibility based on needs
7. In-service and staff development

INITIAL STUDENT REVIEW REFERRAL POINT

As teachers start to work with their classes each year, certain students begin to stand out as having particularly unique problems and/or needs. When these existing needs warrant attention, the classroom teacher asks for a consultation with the Facilitator. After discussing the suspected problems, the Facilitator conducts an observation of the classroom environment. At this point, several options exist to remediate the identifiable needs of the student.

One alternative is to team with the teacher to develop individual programming within the classroom and to incorporate as many modifications as possible. The Facilitator aids the classroom teacher in implementing this plan through team teaching, direct demonstration teaching, etc. If after all these modifications have been tried and the student is still having difficulty in the classroom, the Facilitator then asks the classroom teacher to complete a referral form which includes: 1) documentation of any curriculum modifications and their success rate, 2) explanation of any parent contact, 3) a survey of the special needs to com-

plete a profile on the student; and 4) questions on academic behavior and achievement levels and the rate of learning. The data on this completed referral form is compiled by the Facilitator and directed to the Child Study Team.

## II. COORDINATION OF ASSESSMENT PROCESS

In each facet of the Facilitator role, "getting to know kids well" is essential for success. Whether it be in Level II service or in the development of the IEP, the basis for all activities or programs is a clear understanding of the distinctive characteristics of each student.

The Facilitator, regardless of training and experience background, must develop expertise in classroom observation. The observation can be either 1) "screening observation" which is done to identify the presenting problem(s) and questions which must be answered through formal assessment or 2) "formal assessment ovservation" which gathers data about the student's life space. This data will be used in the Needs Determination.

Another task for the Facilitator is the coordination of the assessment assignments for each "area of student functioning". Where the diagnostic picture is particularly unclear, the Facilitator will assure that at least two means of investigating a specific area of student functioning is utilized. To insure successful coordination, a Testing Checklist is provided and each assigned testor indicated tests used in the assessment process.

In summary, the Facilitator must do the following in coordinating the assessment process: 1) determine assessment needs on all referrals; 2) notify parents of intent to assess; 3) implement due process procedures if disagreement exists; 4) if agreement is obtained, make assessment assignments, including those outside the building; 5) develop time line for assessment completion and 6) take direct responsibility for specific assessments as appropriate.

## III. COORDINATION AND SCHEDULING BUILDING CHILD STUDY TEAMS

In addition to being the coordinator of the assessment process, the Facilitator assumes the responsibilities of leading and scheduling the Child Study Team

in the building. Within this framework, there are various tasks which must function smoothly to assure an efficient process to determine and plan for the needs of special students. At each decision level regarding special education services, the Facilitator assures that there is parent participation. The Facilitator is usually the primary contact person with the home though it could be the classroom teacher, social worker, nurse, or any other staff member willing to assume the responsibility. The Facilitator must clarify the purposes for the home contacts and assure their actual occurence.

Another important task in coordination is the maintenance of sufficient dated records of the child study activities. These records include parent communications, assessment assignments and findings, team assessment summaries, staff decisions, IEPs, etc.

The Facilitator must regard the "managing" of the staffing process as a critical responsibility and develop and follow a tight agenda. Task expectations and team member roles must be identified at the outset. As assessment data is gathered, the Facilitator coordinates each testing summary with the data. The Facilitator provides for the "maintenance needs" of each member, supports an accepting atmosphere, does not demand participation, and discourages the domination of the meeting by a few staff members. Perhaps the most difficult task involved in the Child Study meeting is to assure that the majority of time is devoted to the determination of program needs and to the inclusion of organized program interventions into an individual education plan. Once the interventions and modifications are decided, the principal makes specific implementaion assignments. This may include an explanation to those not in attendance at the staffing of their involvement in the specialized service plan.

In summary, the Facilitator sets up the staffing, establishes the agenda, notifies all participants of the meeting, and conducts the meetings. In addition, the Facilitator assists in the IEP writing, if needed, arranges for the case manager's monitoring plan, and acts as liaison between the home and school personnel.

Assistance is given in implementing the IEP program within the building, communicating with the Special Education office and receiving schools, etc. These role definitions impose grave responsibilities on the Facilitator to assure that all legal, educational and emotional support is given at appropriate times and places to both home and school.

## IV. FACILITATOR OF THE COMMUNICATION PROCESS

The building principal is always responsible for giving assignments to staff, for supervising the quality of work, and for assuring its completion. The Facilitator must work within the authority provided by the principal. The Facilitator is not responsible for staff production, staff supervision, nor reprimands. The Facilitator is the principal's agent for identifying tasks that must be assigned, for matching staff member expertise to the tasks, and reporting the principal's assignment requests to the appropriate staff members. When problems with these assignments occur, the principal takes direct responsibility for problem-solving.

The Facilitator acts as a catalyst, bringing out the best in other staff members. Empathy, not sympathy, must be utilized in being sensitive to the other's situations. All work with the classroom teacher and/or the special education teacher must begin with their present level of expertise and personal development. Consistent support must be provided while not losing sight of the original goal which is providing appropriate materials and programs for the student.

The Facilitator must learn to utilize all means of communication, keeping in mind that it is the students who will benefit with the maintenance of open communication. The methods of communication can vary from verbal interactions in the hallways or lounge to formal memos on staffings with parents. The importance of mainstreaming these channels with all staff members and parents cannot be over emphasized. Several types of communication which have been found to be necessary are: meeting notifications as to time, place, and people; child study agendas which are published at least two days prior to the proposed meeting date; phone calls to parents; notification to other staff members that assessment may begin

as parental permission had been received; consultation logs listing staff name, date, purpose, outcome, etc.; profile compilation of special needs for referred students; observation charts for classroom observations; reports on staffings held with staff members after observations, diagnostic teaching, demonstration teaching and follow-up observations in classroom. The building in which the Facilitator works will dictate the type, form and amount of communication needed for smooth performance of the educational programming.

## V. INSTRUCTIONAL PROGRAMMING AND MODIFICATIONS

The regular class teacher has the basic responsibility for establishing the instructional objectives in the classroom. This is accomplished by defining the subject matter to be taught (both cognitive and affective), determining gauges for assessing objective achievement and establishing the basic methodology for instruction. From the basic objectives established by the classroom teacher, the Facilitator helps to identify areas in which either the learning expectations and/or instructional methodology need modification for a particular student. After sharing these observations with the classroom teacher, an agreement must be reached with the classroom teacher before the Facilitator may assume any more responsibilities for program adaptations. As a teamwork relationship develops, the teacher is receptive to ideas and recommendations from the Facilitator regarding objectives and instructional methodology.

The Facilitator is concerned with process (activities, interaction, payoffs, etc.) as it affects meeting instructional objectives with handicapped students in regular classes. Therefore, an assessment of the student in the regular class environment, his interaction with this environment and the student's interests, aptitude, and aspirations must be completed. The development of a hypothesis about alternative instructional modes, uses of additional curricular aids and the structural means of utilizing these new alternatives needs to be considered.

The Facilitator is not in charge of the affective curriculum as it is the responsibility of the regular class teacher. The Facilitator, however, may have an

important role in creating an awareness of affective curriculum content in classroom planning. Affective curriculum may be the lesson "content". That is, the lesson may be on the subject of people's attitudes, feelings, emotions, etc., their development and subsequent effects. Or, the affective emphasis in the curriculum may be in the "process"; rather than "content". In an affective "process" curriculum, the way activities are structured, the behaviors that are reinforced, and the interactions that are modeled become the means for learning.

To this entire process, the Facilitator contributes a wealth of knowledge concerning student motivational systems, encouragement techniques, self concept issues; cooperation/competition issues; communication skills training (stating feelings, being a good listener). In addition, the Facilitator is an observer of the affective climate in the classroom. Important observation by the Facilitator includes: 1) pinpointing the interactional processes that are positive and growth producing and 2) identifying areas in which interactions may be producing student discouragement, tension or need for negative attention. The Facilitator also researches appropriate literature constantly for ideas and materials to aid in implementing an affective curriculum.

Within the realm of programming modification, the Facilitator may have to do an assessment of the student's learning modes and learning styles. The identification of the student's processing strengths and weaknesses, skill and basic information gaps, and a comparison of his/her functional level in the classroom to his/her functional level in a one-to-one setting is completed by the Facilitator. The Facilitator then becomes involved in the location of curricular aids and alternative basic skill curricular materials appropriate to the student's needs. The Facilitator may need to become involved in the creation and rewriting of curricular materials. These newly developed materials are then coordinated with the classroom instructional objectives and instructional plan.

As these additional materials are being incorporated into the instructional plan, there must be an accompanying development of a reward system for student effort and initiative. The Facilitator helps devise a method for recognizing

accomplishment, reinforces the belief that an earnest attempt is worth the greatest reward, and takes the time to learn which form of reward is motivating to the student.

VI. SPECIFICALLY DEFINED TEACHING RESPONSIBILITY ON A NEEDS BASIS

The Facilitator should never be regularly scheduled with teaching responsibilities or the remaining tasks listed under the job description will not receive full attention. Rather, the Facilitator should be free to assist the classroom teacher when certain handicaps or conditions make this adaptation appropriate. In this circumstance, the classroom teacher will lead the lesson while the Facilitator observes, works with a small group or adapts and assists in teaching the lesson.

As a part of the Level II Consultant role, it may become necessary for the Facilitator to do some diagnostic teaching with a selected group of students in order to determine which teaching strategies and materials the referred student might need. The Facilitator may be asked to tutor a student until he/she can fit into an existing group in the building.

As a last resort, the building principal might ask the Facilitator to substitute in a classroom if an emergency should arise when the regular teacher must leave and no regular substitute is available. This facet of the role should only be used in cases of dire need as a Facilitator is not a sutstitute teacher but an additional staff member concerned with improving the educational and affective environment of the students.

VII. INSERVICE AND STAFF DEVELOPMENT

A vital element of a successful education program for a handicapped student is the attitudes of the regular class teacher and other students toward the handicapped student. Therefore, extensive inservice must be provided to parents, staff members, aides, and all students to ensure the successful programming of each handicapped student. Consequently, the Facilitator should work closely with the building principal in developing a mainstreaming staff development plan

as required by the federal and state laws. Topics to be addressed includes: P. L. 94-142; handicap awareness and sensitivity training; teaching strategies and self-concept development activities, etc. If the Facilitator and building principal do not feel that they have sufficient background information to accomplish these awareness tasks, the Facilitator will identify resources and staff to conduct the mainstreaming staff in-services. The Facilitator may also lead or present at these in-service sessions.

Besides in-servicing the staff, The Facilitator will also work on developing a program or plan for a handicap awareness program for the whole student body (K-6). This plan should include location of resource, personnel, films, filmstrips, books or magazines for the media center, etc. Again the Facilitator may assist in presenting the student handicap awareness program to the student body.

While working directly with the principal, the Facilitator should be continually locating magazine articles, newspaper clippings, etc, that can be added to the weekly staff bulletin written by the principal. These articles will provide constant personal growth material for all staff and ensure that sensitivity to handicaps is being instilled.

## EVALUATION COMPONENT OF PROJECT

Because the Facilitator role model is an experimental extension of the special education services continuum, an ongoing evaluation must be conducted annually. This should be done to ensure that all seven tasks described in the initial job description are being completed effectively and that positive attitudes of the regular class teachers are being strengthened regarding mainstreaming the handicapped students in a school building. The evaluation should consider two areas: 1) attitude survey of the staff about the mainstreaming of handicapped students and 2) actual job tasks listed in the original job description.

## FACILITATOR ROLE SUMMARY

I. COORDINATION

200

A. Assessment

1. Reviewing and interpreting previous assessments

2. Planning assessments

3. Assigning and gathering assessments

B. Utilizing Resources

1. Exploring school/community resources

2. Parent participation

3. Facilitating sharing of information

a. All vital persons present

b. Clarifying what is said

c. Use agenda

d. Keeping minutes

4. Formulating IEP writing with team

a. Assigning case manager

b. Getting principal support for plan

c. Arranging reviews

d. Develop an evaluation method for plan written

II. CONSULTATION: PLANNING LEAST RESTRICTIVE ALTERNATIVES

A. Support For Shared Responsibility For Situation

1. Student centered (providing assistance to modify environment to meet student's needs)

2. Program centered (to use building information to plan and implement system change)

3. Staff centered (assist staff in understanding and providing for student's special needs)

B. Focusing Assessment Data on Alternative Interventions

C. Evaluating Intervention for Its Success

III. ADVOCACY

A. Student Advocacy

1. Forming a direct relationship with student

2. Facilitating understanding student and school personnel

3. Insuring appropriate program and monitoring success

4. Insure student's view is known and presented

B. Due Process

1. Guaranteeing procedures are clarified and followed

2. Insure opportunity for full parent participation in assessment, planning, and monitoring

3. Assisting the case manager in periodic reviews

# COMPUTER ASSISTED INSTRUCTION:

# NEW HELP FOR SPECIAL EDUCATION STUDENTS

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Computer assisted instruction (CAI) holds substantial promise for the field of special education. The availibility of low-cost micro-computers makes it economically feasible to use this new technology. However, the development of the computers ("hardware") has out-paced the development of programmed instructions to the computer, called software or more appropriately, courseware. The future development of appropriate courseware will require interaction between computer programmers and educators. Moreover, much of this interaction will have to occur in a research-oriented setting. Only this will allow a determination of how CAI can best be used in special education settings.

In the brief history since the advent of the micro-computers, it is clear that large companies which deal in hardware and software markets have concentrated on video games for entertainment and educational courseware for normal children and adults. We feel that the potential benefits for mentally handicapped students have been largely unrecognized. This paper will discuss several important aspects of CAI in special education settings and make some predictions about future directions for the field.

What are the important characteristics of CAI? We will discuss four primary aspects of this mode of instruction: Individualization, feedback characteristics, overlearning and "fairness".

Individualization refers to the capability of an instructional modality to treat each student as an individual with his/her own particular strengths and weaknesses. A major characteristic of mentally handicapped children is varying and delayed rates of learning. Often, they will learn things in an "uneven"

manner, having picked up some components of a skill but not others. Severely retarded children often cannot learn skills through imitation of the whole skill but rather must learn in small steps, carefully broken down and with immediate positive reinforcement after each step. Examples of these types of skills might be time-telling, letter and shape recognition and money handling. The use of CAI in these situations is perfectly suited to permitting the student to go at his own pace and in an incremental way. As many trials as are necessary to learn a step in the program can be presented. If a student appears to be "stuck", the computer can automatically go to a branching procedure, in which that step is broken down even further to allow continued progress through the program. Moreover, the computer can be programmed to do "error analyses", in which trends can be detected (for example, the student consistently misspells one type of word or cannot match letters or symbols of a particular type) and appropriate remedial sequences can be automatically activated. To the extent that CAI can be individualized, there is the obvious additional advantage for small or rural school districts whose classrooms (self-contained or mainstreamed) contain a heterogeneous mixture of students with a variety of mental or emotional disabilities.

Feedback is one of the most important aspects of efficient learning. Generally speaking, feedback in CAI should be information (Magielson, 1977) and immediate (Kulhavy, 1976). Beyond this, however, there is virtually no research which has systematically investigated which kinds of computer feedback maximize machine use, attention to the material and acquisition of skills or knowledge. These factors are especially important in the case of learning or developmentally disabled children who have difficulty attending for sustained periods of time, cannot mediate long delays of reinforcement and for whom overlearning of material is especially important. For purposes of conceptualization, we classify motivational feedback in four categories: 1) Passive feedback, in which basically neutral information regarding response adequacy is conveyed; 2) Active feedback, in which a variety of sensory stimulation (auditory and visual) is presented con-

tingent upon correct responses; 3) Interactive feedback, allowing interaction with the computer (e.g., a computer game) and 4) External feedback in which feedback or reinforcement is dependent on CAI performance but controlled externally (e.g., a token system). Our prediction is that CAI will go through several stages of feedback development, eventually centering on a form of interactive feedback. Sometimes called "edutainment", this type of feedback will essentially integrate education software with entertaining interactive feedback, hence the term. While there are programs now which claim to integrate entertainment with learning, it will be several years before sophisticated versions of edutainment which can demonstrate efficient learning appear.

CAI is very suitable for learning skills and knowledge which require large amounts of drill and practice. The importance of overlearning has long been recognized in education and refers to improved retention as a result of practice beyond the usual criterion level for acquisition. A computer is infinitely patient and will present learning trials and give feedback as long as a student needs in order to master a concept. Also, because the machine doesn't tire of this tedious repetition, it cannot become frustrated and angry at a child who is taking "forever" to learn a skill.

A final characteristic of CAI we feel may be important is that the computer is ultimately fair. It cannot discriminate white from black, slow learner from fast learner, the well socialized from the anti-social child. Nor does it harbor pre-conceived notions about the potential of one child versus another. Thus, a handicapped learner never sees and feels the frustration of a teacher or parent doing drill and practice and cannot be the victim of a self-fulfilling prophecy in this regard. Indeed, in our research we have heard comments from children such as "I like the computer, it never gets mad at me." This "fairness" characteristic may result in better learning and to some extent improved self-esteem among handicapped learners.

## FUTURE DIRECTIONS

We envision the micro-computer as having an important, but limited role in the future of special education. CAI is obviously well suited to the teaching of skills which require a great deal of one-to-one drill and practice. We are also looking at its potential for teaching specific decision-making skills. Simulated situations could be displayed on the screen and the learner must respond with a decision. Examples might include, "it's raining outside, what do you want to wear?", or "You have your dark blue skirt on, what color blouse will you choose?" Again, a great deal of drill and practice is required for many students to master these types of skills and CAI is the perfect adjunct. An obvious question which immediately arises is whether this type of simulated practice will generalize to real-life situations. We suspect it will but is is an empirical question which will have to be researched.

We also see a great deal of effort toward individualization of CAI in the future. Researchers will attempt to design programs which will specify a particular instructional sequence depending on the student's IQ, age, sex, disability type and perhaps even certain personality variables which are predictive of CAI performance. On the less positive side, there will probably be a certain amount of active and passive resistance to the use of micro-computers in special education. Some objections will be based on fear of the unknown and others will be based on philosophical concerns about the role of machines in our lives. In spite of this, we predict that the micro-computer revolution will come and that it will prove to be of tremendous benefit to special education teachers and students.

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# IDEAS AND PROGRAMS FOR AUTISTIC CHILDREN IN THE PUBLIC SCHOOL

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The ideas presented here were developed because the children in our program needed to develop and/or improve: eye contact, in-seat behavior, receptive language, attention span, listening skills, following commands, self-concept, body awareness, imitation skills and self control.

We found that the children were more successful if more than one type of stimulation was used to elicit a response. The children also learned faster when a variety of visual, auditory, and touching cues were used. Then the activity also combined a functional purpose with action, the children enjoyed it more and attended to the activity for a longer period of time.

Since we had some children too dependent on edible rewards, we did not use food at all unless it was directly involved with the activity. Instead we used verbal and social praise. Non-compliant children and those learning new skills should be physically guided through the task so they may experience success. This can be a real fight for the non-compliant child but they soon learn that no matter what, they will do it, and they will be rewarded. You, the teacher, will also gain control and needed discipline.

## General Guidelines

1. Don't rush--a trusting relationship between you and each child takes time to develop, a minimum of two months is average.
2. Establish and maintain firm rules and control.
3. Exhibit love and security to the child at all times.

## Eye Contact

1. Hold a bright bead with a piece of food on it directly in front of the

child, slowly move the bead and have the child track it. (The food is the reward for successful tracking)

2. Blow soap bubbles and have the child pop them.
3. Ball throwing
4. Bean bag toss to defined targets
5. Ring toss
6. Poems or songs with actions
7. Demonstrations of simple tasks for child to imitate
8. Paint the drawers of a sewing chest different colors -- place yellow items in yellow drawer, red in the red drawer, etc.

Receptive Language

1. Name familiar objects for the child
2. Have child repeat names of familiar objects, if child is verbal
3. Ask child to choose a particular object from a small assortment and hand it to you
4. Substitute pictures for actual objects and repeat items #1-3
5. Tell a story with picture cards
6. Ask child to repeat the picture card story

Imitation

1. Songs and poems with actions
2. Tap dancing following simple step patterns taped on the floor

Relaxation

1. Going for a walk
2. Running
3. Swinging
4. Water play in a vibrating foot bath
5. Rubbing arms and legs with soft textured materials
6. Listening to classical music, stories, poems
7. Clothing made from soft fabric without excessive buttons and zippers or tight waist bands such as jumpsuits and cover-alls

Self-Concept

1. Upon completion of a task, ask, "Who does good work?"

   Then elicit response "I do good work" from child.

2. Social rewards in the form of clapping, hugging, a kiss on the cheek and verbal praise.

Aversives

1. Time-out
2. Spankings
3. Restraints

   } Depending on individual child and the behavior

4. A time-out room

Self-Stimulation

1. Substitute an acceptable behavior for the undesirable one
2. Permit the self-stimulation behavior as a reward for some other action and then only for a brief period of time

CURRICULUM EXAMPLES

Juice Break

1. Making simple foods

   All of our children love popcorn. They assist in getting everything ready.

2. Having the children ask for what they want or just to make a sound before they get the snack.

3. Have the children assist with pouring, setting and clearing the table.

Objectives and concepts to be learned

1. Standing in a line to get tray or plate.
2. Concepts of one-to-one placement (giving each child a glass, placemat, etc.)
3. Patience
4. Verbalization
5. Self-help skills

Commands

1. Following visual demonstration.
2. Following verbal instruction.
3. Following two part commands.
4. Following three part commands.
5. Following four part commands.
6. Learning new concepts.
7. Reasoning and concentration skills.
8. Verbalizing what they have just done.

Gardening

1. Making potting soil
2. Planting and growing plants
3. Making decorative containers
4. Plant decorations

Objectives and concepts to be gained

1. Reading directions (one student at present time)
2. Number concepts
3. Measuring
4. Following directions
5. Individual and group work
   - A. Attention span
   - B. Work concepts
   - C. Behavior control (compliance)
   - D. Following directions
   - E. In-seat behavior
6. Speech and language concepts
   - A. Directions
   - B. Naming objects
   - C. Functional words
7. A future recreational or work type skill
8. Matching by colors
9. Using a variety of materials

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Field Trips

1. Go to different types of stores and businesses
2. Go to a variety of recreational activities
3. Go into the community for a specific reason

Concepts and objectives

1. Behavior control in a public gathering (large group situation)
2. Compliance
3. Following safety rules
4. Observation of environment
5. Receptive language and speech
6. Public awareness and public relations

Walks

The first activity of the day is to take a 10 - 20 minute walk. This has always seemed to get rid of extra energy and get the children ready for the school day.

Music

1. Records, tapes, books, poems

Concepts and Objectives

1. Relaxation
2. Use of materials
   record player
   tape recorder
   rhythm band instruments
   tap shoes
   scarfs, ribbons, pom poms
3. Dressing
4. Self - expression
5. Patterning
6. Speech and Language
   Memorization
   Rhythm
7. Emotions (self - expression)
8. Behavior change
9. Body awareness

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Logs

1. Measuring
2. Sawing carpet tubes
3. Stuffing logs

Objectives and concepts

1. Measuring
2. Attention span
3. Behavior control
4. Speech and language
5. Counting (numbers)
6. Following directions
7. Learning a multiple step task
8. Giving
9. Coordination
10. Eye contact

Art

1. Use a variety of materials and textures to make decorations or just to use materials for self expression
2. Play different types of music (sad, happy, fast, slow, etc.)

Concepts and objectives

1. Use of a variety of materials
2. Color concept
3. Use of brushes, pasting, coloring, scissors, yarn, etc.
4. Self-expression
5. Self concept
   A. Feeling of accomplishment

Tearing Foam

1. Tear foam carpet padding into small pieces to be used for stuffing.
2. Put small pieces into individual containers at desk. When these are filled then they can be emptied into a plastic sack.

Objectives and concepts to be gained

1. Independent work
2. Increase attention span
3. Since autistic children often tear paper, for self-stimulation, this activity fills that need of self-stimulating and is a relaxing, calming down activity.

GOOD-BYE, IMPEY

(Say the refrain together)

Who tracked that mud upon the floor?

Who just went out and slammed the door?

Must be Impey!

Who left his jeans upon the chair?

Who threw waste paper over there?

Must be Impey!

Who came to dinner very late?

Who grabbed the cookies from the plate?

Must be Impey!

Who hollers back and won't say "please"?

Who is a nuisance and a tease?

Must be Impey!

If Impey comes around today,

Don't be surprised if we should say,

Good-bye, Impey!

# APPENDIX

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